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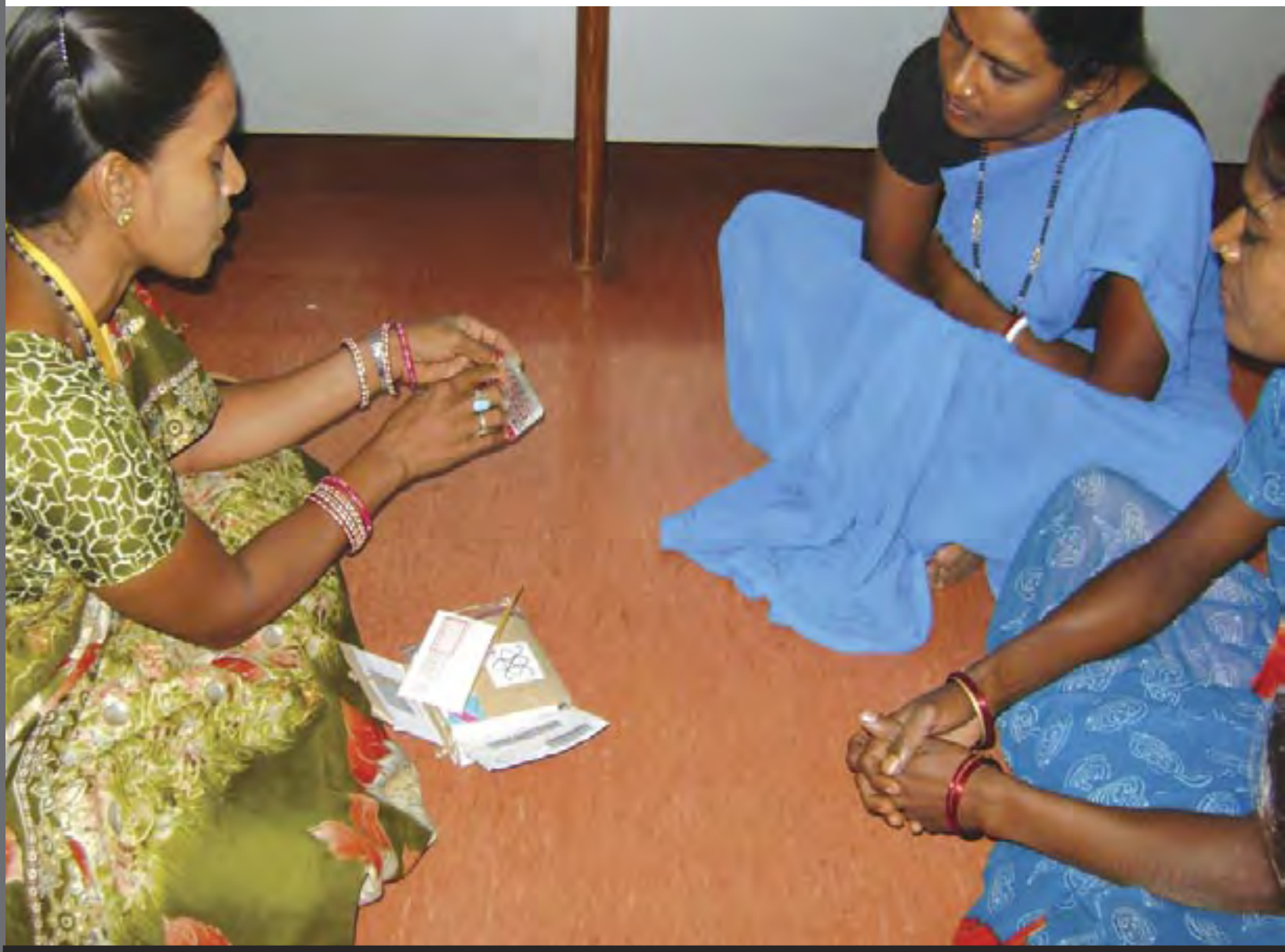






Behavior Change Communication Activities and Achievements

Innovations in Family Planning Services Technical Assistance Project (ITAP)

Lessons Learned, Best Practices and Promising Approaches

June 2010

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Foreword

In the year 2000, India was home to more than one billion people, one-sixth of the word's population. The country's population is projected to increase by 60 percent, to 1.6 billion by the year 2050 (United Nations *World Population Prospects,* 2008). This large population and projected rate of growth present major challenges to health and resources for the world's largest democracy.

India has made significant strides in improving the health of its people. A reduction in fertility by 48 percent (from 5.2, 1972 to 2.7, 2005-06), and increase in contraceptive use of 38 percent (from 40.7, 1992-03 to 56.3, 2005-06) are indicators of progress. However, variances in health across sectors of the population, and prevailing rates of high fertility in northern states, such as Uttar Pradesh (UP), where fertility is 4.1 in rural areas (2005-06), highlight the need for continued efforts on family planning (FP) and reproductive health (RH) programs to improve health.

From 2004-10 the United States Agency for International Development (USAID) and the Government of India delivered innovative initiatives to expand access to FP/RH products and services among underserved populations through the Innovations in Family Planning Services-II (IFPS-II) project, a follow-up from the successful bilateral IFPS-I project (1992-04).

Under IFPS-II, behavior change communication (BCC) strategies were employed to generate demand for the uptake of FP/RH products and services to improve health among populations with low access to such services in UP, Uttarakhand and Jharkhand. BCC initiatives were developed and delivered in collaboration with key stakeholders – the National Rural Health Mission (NRHM); State Innovations in Family Planning Services Agency (SIFPSA); Government of India; Government of UP, Uttarakhand and Jharkhand; and district and block health program workers. BCC strategies have now become integral to India's Program Implementation Plans under the NRHM, and have positively influenced health programs from state level development through program managers, to community level delivery through frontline health workers across the country.

This document presents lessons learned, best practices and promising approaches of the BCC initiatives developed and delivered under IFPS-II. It seeks to provide a reference, along with insights and guidance, to policymakers, program planners, and implementers to contribute to achieving the goals of the country through improved health of women, children, families and communities.

Sincerely,

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This BCC Documentation Report was developed by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) under the IFPS Technical Assistance Project (ITAP). It was authored by Heer Chokshi (BCC Specialist), Meenakshi Dikshit (BCC Specialist), Michael Kelly (Graduate Intern), and Kimberly Rook (Program Officer II). Additional contributions were made by Geetali Trivedi (Senior Program Officer) and Basil Safi (Asia Team Leader).

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June 2010
New Delhi
INDIA

Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCIS	Behavior Change Impact Survey
BHC	Block Health Center
BISR	Birla Institute of Scientific Research
BPL	Below Poverty Line
BPM	Block Program Manager
CH	Child Health
CHC	Community Health Center
CINI	Child In Need Institute
CMO	Community Mobilization Officer
CPR	Contraceptive Prevalence Rate
DAVP	Directorate of Advertising and Visual Publicity
DCM	District Community Mobilizer
DHEO	District Health Education Officer
DHEIO	District Health Education Information Officer
DLHS	District Level Household and Facility Survey
EAG	Empowered Action Group (states)
EE	Entertainment-Education
FP	Family Planning
FWC	Family Welfare Counselor
GOI	Government of India

HEO	Health Education Officer
HIHT	Himalayan Institute of Health Training
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IFPS	Innovations in Family Planning Services
IRH	Institute for Reproductive Health
IPC	Interpersonal Communication
IPC/C	Interpersonal Communication/Counseling
IPHS	Indian Public Health Standards
ITAP	IFPS Technical Assistance Project
IUD	Intrauterine Device
IUCD	Intrauterine Contraceptive Device
JHS	Jharkhand Health Society
JHU/CCP	Johns Hopkins University Center for Communication Programs
JSY	Janani Suraksha Yojana (Safe Motherhood scheme)
LAM	Lactational Amenorrhea Method
LHV	Lady Health Visitor
MCH-STAR	Maternal and Child Health Sustainable Technical Assistance and Research Project
MGHN	Merrygold Health Network
MH	Maternal Health
MIS	Management Information Systems
MOHFW	Ministry of Health and Family Welfare
NFDC	National Film Development Corporation
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHSRC	National Health Systems Resource Centre
NRHM	National Rural Health Mission
NRS	National Readership Survey
NSV	No-scalpel Vasectomy
OCP	Oral Contraceptive Pill

ORS	Oral Rehydration Solution
PFI	Population Foundation of India
PIP	Project Implementation Plan
PHC	Primary Health Center
PMU	Program Management Unit
PNC	Postnatal Care
PNH	Population Nutrition and Health
PPFP	Post Partum Family Planning
PPP	Public-Private Partnership
PRI	Panchayati Raj Institute
PSU	Primary Sampling Unit
PPS	Probability Proportional to Population Size
RH	Reproductive Health
RCH	Reproductive and Child Health
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SDM	Standard Days Method
SIFPSA	State Innovations in Family Planning Services Agency
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
ToT	Training of Trainers
TRP	Television Rating Points
UDAAN	Understanding and Delivering to Address Adolescent Needs
UKHFWS	Uttarakhand Health and Family Welfare Society
UP	Uttar Pradesh
USAID	United States Agency for International Development
VHSC	Village Health and Sanitation Committee
WHO	World Health Organization

Contents

Introduction

Innovations in Family Planning Services – I

Launched in 1992, Innovations in Family Planning Services (IFPS) was an ambitious 12-year bilateral project funded by the United States Agency for International Development (USAID) that expanded and improved family planning (FP) and reproductive and child health (RCH) services in UP, India's most populous state. IFPS-I achieved many milestones and made significant contributions to the health of women, children and families in Uttar Pradesh. Major achievements include the development of an autonomous agency to oversee management of activities – the State Innovations in Family Planning Services Agency (SIFPSA); a strengthened public healthcare system for the provision of FP and RCH services through technical assistance, training, and capacity building; engagement of the private sector bringing FP and RCH services to rural and hard-to-reach populations; and increased access to products and services through social marketing and behavior change communication (BCC).

Innovations in Family Planning Services – II

Now in its second phase, IFPS-II is a six-year bilateral project (2004-10) funded by USAID addressing FP and RCH in three northern states – Uttar Pradesh, Jharkhand and Uttarakhand. The IFPS-II project is implemented by SIFPSA in UP, Jharkhand and Uttarakhand. Technical assistance is provided by a consortium of technical agencies led by the Futures Group International, in partnership with the Johns Hopkins University Center for Communication Programs (JHU/CCP), Bearing Point, QED Group and the Urban Institute.

Following the first phase of IFPS, IFPS-II continued in 2004 to develop, demonstrate, document and leverage the expansion of public-private partnerships (PPPs) for the

provision of high quality FP, reproductive health (RH), and child health (CH) services to improve health outcomes in the region. The project developed and demonstrated models of PPPs including social franchising of the Merrygold Health Network (MGHN), expansion of a basket of contraceptive products, promotion of mobile health services, and collaboration with traditional medical providers in tribal communities. Through these activities, the project developed, demonstrated, documented, disseminated and leveraged expansion of effective partnership models. IFPS-II implements BCC and marketing strategies to increase demand for FP and RH services and products in UP, Jharkhand and Uttarakhand.

JHU/CCP, as the lead partner in developing BCC strategies, provided technical assistance to the Government of India; Governments of UP, Jharkhand and Uttarakhand; SIFPSA; the National Rural Health Mission (NRHM); district and block health program workers; and local implementing partners under IFPS.

Background

Family planning and reproductive health have been the priority health areas in India for more than three decades. Many programs have been implemented to increase awareness, access to, and use of FP and RH products and services, and much progress has been made. The overall population growth rate declined from 2.2% in 1990 to 1.5% in 2006, and similarly, total fertility decreased from four children per woman in 1990 to 2.6 in 2006.[1] In spite of these efforts, by 2030, India is poised to surpass China as the world's most populous country, and mortality rates of mothers and newborns remain high in parts of the country including the northern states.

The IFPS project was designed as an FP intervention in 1992 with the main goal of reducing UP's total fertility rate (TFR) from 5.4 children per woman to 4, and increasing the contraceptive prevalence rate (CPR) from 35% of married reproductive age women to 50% (USAID/India, 1992). Uttar Pradesh is the most populous state in India with a population of 167 million. Its large population combined with its vast geography and largely rural communities make the delivery of healthcare products and services challenging. This can be seen in the health indicators of UP, which historically are significantly worse than health indicators of India overall. A major focus of the IFPS project since inception has been the development and delivery of FP, RH, maternal health (MH) and CH interventions, targeting the most marginalized populations with a special focus on UP.

NFHS-3 (2005-06)	All India	UP	Uttarakhand	Jharkhand
CPR (any method) %	56.3	43.6	59.3	35.7
TFR	2.68	3.82	2.55	3.31
ANC (3+ visits) %	52.0	26.6	44.9	35.9
Institutional delivery %	38.7	20.6	32.6	18.3
Full immunization % (12-23 months)	43.5	60.0	34.2	46.6

[1] World Health Organization, WHO Statistical Information Systems, 2010

Reducing Fertility and Improving Health

IFPS-II aimed to reduce fertility and improve health in targeted areas of India by increasing the demand for and uptake of FP and RH services, and increasing the use of behavioral interventions for Human Immunodeficiency Virus (HIV) prevention, child survival, and infectious disease. By addressing total fertility and contraceptive use, and integrating underlying factors of MH, CH, and nutrition, IFPS-II has made many great strides that are presented in this report.

Behavior Change Communication

Goals of BCC for IFPS-II

Overall, the primary objectives of the project are to achieve the following with the close support and integration of BCC:

- Incorporate best practices in RCH when models of PPP are developed, demonstrated and documented.
- Form linkages with Indian technical organizations to deepen the already strong national capacity for international quality technical assistance.
- Assist in the establishment and nurturing of the National Health Systems Resource Centre (NHSRC).
- Develop the capacity of the state and national public sector to enter into partnerships with the private sector.
- Incorporate sustainability considerations and replication strategies into models and systems from the outset and bring these models to scale with resources from other sources.
- Facilitate collaboration between public and private sectors in efforts to address family planning and reproductive health needs.
- Ensure high standards of care.
- Build the capacity of local organizations to meet the needs of their communities.
- Increase the use of research to refine and improve program approaches.

Strategic Approaches to BCC

The BCC strategy for the NRHM began with the prioritization of behaviors for change based on individual health needs in each of the three target states. With this information, a roadmap of interventions was assimilated, designed and implemented to address those needs through state, district and block level program managers.

Key elements of the BCC strategy:

- Priority behaviors and targeted interventions addressing the most critical health needs
- Activities and interventions delivered through converging channels of communication
- A coordinated implementation plan for interventions across the state of UP, and its districts and blocks delivered through health program managers and workers at all levels.

This strategy recognizes the importance of using a mix of media to reinforce messages and ensure sustainable behavior change. The core of the strategy has revolved around: (1) interpersonal communication (IPC)

and community level BCC activities, with support from (2) mass media and (3) community mobilization. IFPS-II and the NRHM worked together with other stakeholders to select five core health areas for intended behavior change. All interventions and activities delivered through IPC and community events, community mobilization, and mass media are coordinated and focused accordingly to achieve the overarching objectives. By following this schedule yearly, community based activities have been coordinated with state level mass media efforts, and IPC through local health workers, thereby reinforcing messages and supporting behavior change at the community and household levels.

Uttar Pradesh

BCC activities in UP culminated in the development of BCC strategy for the NRHM and a companion implementation guide for district and block level health program managers, addressing priority health behaviors. Numerous BCC activities were developed to increase knowledge and awareness of, and demand for FP/RH products and services. Additional activities were conducted to advocate for improved service access and utilization, and to build capacity among mid-level health program managers within the state, districts, blocks and frontline healthcare workers such as accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs). Activities delivered in UP engaged the private sector and employed mass media, entertainment-education (EE), community mobilization, and capacity building strategies.

Jharkhand

BCC activities undertaken by IFPS-II began in Jharkhand in 2004. To improve the health of populations, IFPS-II assisted in the development of a state BCC strategy for priority health areas, with special emphasis on the needs of tribal populations unique to the region. Attention was given to improving capacity for intra-communication across stakeholders, and IPC of Sahiyas or community health workers. Additionally, generating demand for FP and RCH services available through government schemes was important. IFPS-II implemented the Sambhav Voucher Scheme as a PPP initiative for which a range of BCC materials were developed to generate demand for FP products and services.

Uttarakhand

BCC activities undertaken by IFPS-II began in Uttarakhand in 2004. To improve the effectiveness of existing BCC programs for FP and RCH services, IFPS-II provided technical assistance on an activity-by-activity basis. Utilizing this approach, IFPS-II in collaboration with the Government of Uttarakhand, developed BCC to support various PPP initiatives including Mobile Health Vans, FP and RCH Voucher Schemes, and pilot programs like adolescent health and the ASHA Plus program. All of these programs began as pilot projects, and most models were subsequently adopted by the Uttarakhand Health Society, and scaled up to reach more families and communities. The need still exists in Uttarakhand for an overarching BCC strategy to improve health in this remote and mountainous region of India.

Intended outcomes

	Strategy Development	BCC Campaigns/Material Development			BCC Capacity Building	BCC in Social Marketing/ Franchising
		Mass media	Mid-media	IPC/ Community Level		
National		Campaign 2004-09 Campaign 2009-10 (3 phases) NRHM advocacy film Atmajaa Tele Series			National IEC/BCC Workshop	
Uttar Pradesh	NRHM BCC Strategy 2008	Multimedia Sterilization Campaign 2004 Radio Series –Sanwarte Sapne Sunehri Rahein	Comprehensive Poster on Family Planning ASHA Newsletter Immunization – jachcha-bachcha raksha card Folk Media - Street plays, puppet and magic shows	Saloni Diary	Distance Learning Program NRHM Flipbook for ASHA Saloni Teachers' Training Manual Family Welfare Counselors Training Module Regional BCC capacity building	Communication Plan for MGHN Vouchers for various services under Voucher Scheme
Uttarakhand	BCC strategies for specific programs: • Mobile Health Vans • Voucher Scheme • Adolescent Health	Institutional Delivery Campaign Immunization Campaign	UDAAN-Adolescent Health Program Voucher Scheme Demand Generation Mobile Health Van Demand Generation	ASHA Plus Program		
Jharkhand	Health Communication Strategy Health Issues and Health Seeking Behaviors of Tribal Populations	Spacing Campaign	Voucher Scheme Demand Generation	IPC toolkit for Sahiyas (ASHAs)	Intra-communication IPC for Sahiyas (ASHAs)	

SECTION I

आबादी का बढ़ता बोझ
साधन घटते जाते रोज

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

Behavior Change Communication

National Level

SECTION 1

Behavior Change Communication

National Level

BCC activities undertaken by the IFPS-II project at the national level focused on FP and RCH, with emphasis in UP, Uttarakhand and Jharkhand following evidence-based strategic approaches to health communication. BCC program components at the national level consisted of Information, Education and Communication (IEC)/BCC mass media, assessment, sustainable BCC development, capacity building, EE, and advocacy with the goal of increasing awareness and knowledge, improving attitudes, generating demand, and positively changing behaviors related to FP and RCH.

With the launch of the NRHM in 2005, IFPS-II provided all pre-2005 BCC materials to the NRHM and the Ministry of Health and Family Welfare (MOHFW) for broad dissemination throughout the states and districts. Between 2005 and 2009, IFPS-II managed the development of various BCC campaigns that focused on FP and RCH through IEC and BCC for distribution through mass media outlets – TV, radio and print. Starting in June 2009, a roadmap for a three-phase national mass media campaign to reinforce initial IEC and BCC messages was laid out for creation and dissemination in May 2010. Other activities conducted at the national level include a study on assessing visibility, comprehension and recall of TV campaigns aired under the NRHM; capacity building through a national IEC workshop; Atmajaa, a TV serial drama; and an NRHM advocacy film.

Mass Media

Since the launch of the NRHM in 2005, IFPS-II has been recognized as the technical advisor in the area of BCC campaign and material development. IFPS-II assisted the NRHM in creating a range of TV and radio spots on priority health themes including FP, age at marriage, the role of the NRHM in promoting health and preventing disease, HIV/AIDS, antenatal care (ANC) and immunization. IFPS-II developed over 20 TV and radio spots for the NRHM which aired on cable and satellite channels in India over two phases between 2005 and 2009. The TV and radio spots largely rely on social and behavioral theory by promoting benefits and addressing barriers to behavior change, and employing role models.

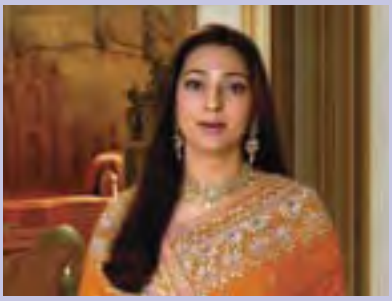
NRHM BCC Campaign – Phase I

In this first phase, IFPS-II created TV and radio spots for the NRHM from May through October 2006. Some TV spots were exclusively designed for and aired by MOHFW, while others were developed and aired under other programs.

Strategic Approach and Objectives
Through empowerment, using role models, promoting behaviors and benefits, and addressing barriers, motivate audiences to improve attitudes towards and adopt positive behaviors for age at marriage, antenatal care, WHO-ORS, immunization, family planning and HIV/AIDS.

Audience
Couples 20-45 years, and adolescents 15-19 years

Creative Approach
A range of approaches were employed. Some spots used celebrities from Indian cinema and television to share how their lives were impacted by adopting positive health behaviors, and encouraged audiences to adopt healthy behaviors for better health and quality of life. Other spots employed emotional approaches, pulling from cultural and social traditions such as festivals and customs that are rooted in Indian history.

	Theme/Objective	TV Spot	Evaluation Findings
	**Age at Marriage** Encourage completing school and delay marriage until age 18	Emotional black-and-white ad Celebrity ads: • Amitabh Bachchan • Raveena Tandon	People in urban areas recalled seeing the ads more often than people in rural areas; the emotional ad was recalled more often than the celebrity ads.
	**ANC** Benefits and the role of ASHAs and ANMs	'Afternoon gossip' with pregnant woman Celebrity ads: • Juhi Chawla • Pallavi Joshi • Supriya • Amitabh Bachchan	Married women most recalled the Pallavi Joshi ad (33% rural/46% urban), followed by 'Afternoon gossip' (25% rural/41% urban). Married men most recalled the Amitabh Bachchan ad in rural areas (24%) and 'Afternoon gossip' in urban areas (30%).
	**WHO ORS** Benefits and preparation	'School teacher' diarrhea ad Prevent recurring diarrhea - ORS and zinc Celebrity ads: • Sakshi Tanwar • Chef Sanjeev Kapoor	'School teacher' ORS ad was most often seen by married women in rural areas (56%) and urban areas (66%), and by adolescent girls (48% rural/70% urban).
	**Full Immunization**	Celebrity ads: • Amitabh Bachchan • Pallavi Joshi	Less than one-fourth of audiences recalled ads on immunization.
	**HIV/AIDS Prevention**	Celebrity ad: • Amitabh Bachchan	These spots were not evaluated.
	**NRHM Programs**	Role and services of ASHAs JSY Safe Motherhood scheme	

Results
An evaluation was carried out in 2007 by an independent research agency to gauge impact of the spots which were aired nationally on Doordarshan, India's largest TV channel, as well as a range of satellite channels.

Evaluation Objectives
Asses the impact of the mass media spots to inform future BCC mass media strategies. The evaluation looked at:

Visibility of the TV/radio spots
- Reach and exposure
- Effectiveness of media channel and time of airing in reaching intended audiences

Comprehension, Recall and Relevance to the Audience
- Awareness of the NRHM logo
- Recall of content of the spots
- Recall of the main messages communicated
- Relevance and acceptability of the messages

Participants
Rural and urban households in eight Empowered Action Group (EAG) states.[2]

Design
The evaluation was a population-based survey which followed a two-stage stratified systematic random sampling design. At the first stage, 213 primary sampling units (PSUs) such as villages and urban wards were selected through the Probability Proportional to Population Size (PPS) technique in eight EAG states. At the second stage, 3,500 households were selected in these villages and urban wards by means of a systematic random sampling procedure, and interviews were conducted. The number of participants interviewed in selected households were:
- 1,496 married men aged 20-45 years
- 1,588 married women aged 20-45 years
- 779 adolescent boys aged 15-19 years
- 791 adolescent girls aged 15-19 years

Findings
The selection of health themes for the campaign was largely in line with the three broad goals of the GOI's RCH-II program of reducing fertility, infant mortality and maternal mortality.
- Ownership of a functional TV varied from 23% in rural households to 57% in urban households.
- TV viewership was high among men both in rural and urban areas.
- Overall, nearly three-fifths of respondents in each of the target audiences who were exposed to the ads found them to be effective in conveying the intended message.
- In general, a higher proportion of married men and adolescent boys than married women and adolescent girls attempted to take some type of action after seeing the TV spots. This is not surprising, as numerous studies have shown that women often are not empowered to make decisions about their own health and the health of their children. Specific actions included:
  - Gathering more information on an issue after seeing a spot on it
  - Encouraging friends, relatives or others to follow the behaviors, or following the behaviors

[2] EAG states include Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan and Orissa.

communicated through the ad for themselves, their spouse, their family members or children
- The impact of the FP ad is seen by actions taken by married respondents where 58% of married men and 46% of married women reported that they started using a FP method after seeing the ads.

Conclusions and Recommendations

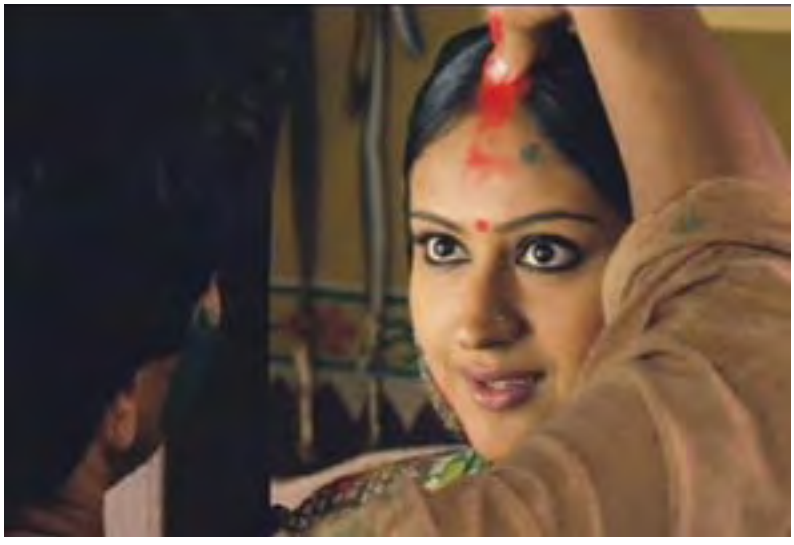
- As RCH-II service delivery is strengthened, the thematic areas for BCC will need to be expanded. However, this should be done within an overarching evidence-based BCC strategic framework. The BCC strategy should be implemented in phases so that efforts are focused and lead to desired behavior change. Too many messages aired less frequently can lead to message dilution.
- Findings from the evaluation indicate that recall and comprehension of the TV spots vary by health theme and creative approach. This highlights the importance of audience segmentation for message design as well as media placement. The third round of the National Family Health Survey (NFHS-3) and the National Readership Survey (NRS) can be excellent data sources for this purpose.
- Another aspect related to audience segmentation is the choice of media channels. Though TV is an important and effective medium, reach among rural audiences in EAG states is limited, albeit growing. For behavior change to occur, TV should be supplemented with other BCC channels including community outreach and IPC.
- The celebrity spots had varying impact with different audiences and health themes. The evaluation also demonstrated that non-celebrity spots can work equally well, if not better than celebrity spots.
- Sustained airing of TV spots is important. Several spots that had higher recall had also been aired through multiple programs, increasing their exposure and subsequently their recall.

NRHM BCC Campaign – Phase II

Between December 2008 and January 2009, the NRHM launched the second phase of the campaign to promote existing health programs and schemes, and improve attitudes towards and increase knowledge of maternal, newborn and child health issues. IFPS-II provided BCC content for the campaign, and development partners including USAID, UNICEF and UNFPA participated in its implementation.

Strategic Approach and Objectives
Through empowerment, role modeling, and promotion of FP choices and benefits:

- Motivate audiences to adopt positive FP and RCH behaviors by addressing key factors that act as enablers and barriers to adoption
- Improve attitudes towards FP and RCH among intended audiences across focused health themes.



Audience
General population 15-45 years

Creative Approach
A range of creative approaches were used, including the use of cultural symbols, festivals and customs that are rooted in traditions of everyday life, and emotionally inspiring lyrics and visuals. This campaign called for promoting health services and schemes of the NRHM, and positioning the ASHA as an important link between health services and families. To achieve this, some spots showcased the high quality of health services, and presented them as within the reach of families through the ASHA. In a few spots, celebrities from Indian cinema and television shared how their lives were improved by adopting positive health behaviors, and appealed to audiences to adopt healthy behaviors for better health and quality of life.

Interventions and Activities
Sixteen television spots, seven radio spots, and numerous print ads across all major national newspapers were

developed, focusing on age of marriage, FP adoption, and the NRHM.

Results

An independent evaluation of the reach, recall, comprehension, appeal and intention-to-act was commissioned by USAID and carried out by Population Foundation of India (PFI) and MCH STAR. The evaluation represented urban and rural areas of select states across India. In-depth interviews with state level policymakers and program managers were held to elicit their perceptions of the recommendations culled from the evaluation.

Key Findings

Reach and Exposure

- Overall reach of the campaigns was high at 86%, and consistent across rural and urban areas.
- Reach of the TV campaigns was almost two-thirds (64%).
- Almost two-thirds (66%) of respondents had a working TV.
- Only one-fourth of respondents had working radios.
- Few households (17%) had mobile phones equipped with FM radio.

Message Recall

- 20-45% of respondents could recall specific messages without prompting.
- 75-95% of respondents could recall specific messages when aided.

Likeability and Appeal

- Most respondents who saw the spots (78-94%) liked them.
- A small percentage of respondents (8-14%) faced difficulty understanding the campaigns.
  - Difficulties included language comprehension, messages were delivered too quickly, or the words were difficult to follow.
- Spots that portrayed people from real life and those with entertaining messages were preferred over celebrity spots.

Intended Behavior Change

- 33-62% of men and 31-50% of women intended to take action such as:
  - Discussing FP or RCH issues with spouse, other family members, friends or relatives
  - Seeking FP and RCH services
  - Adopting behaviors presented in the spot.

Results of the Phase II Campaign Evaluation

N =	3,575 married women 1,784 husbands 350 fathers and mothers-in-law

	Key Message and Creative Approach		Impact				
			Message Recall	Compre-hension	Likeability	Gained new knowledge	Intend to take action
Age at Marriage	Emotional appeal to girls to delay marriage until 18 years	Women	81.6%	92.1%	87.5%	65.3%	48.7%
		Men	83.5%	91.4%	89.5%	61.6%	60%
Family Planning	Celebrity couple Sachin and Supriya encourage couples to adopt FP by sharing personal experiences	Women	41.2%	94.4%	89.8%	68.6%	48.3%
		Men	41.4%	94.9%	88.8%	67.4%	59.4%
	Celebrity Juhi Chawla encourages couples to adopt FP for child spacing and limiting to have a small but healthy family	Women	40.3%	89.1%	87.4%	70.1%	41.2%
		Men	57%	88.5%	82.6%	67.1%	40.6%
	Women discuss contraception choices while applying mehendi or henna, in a cultural setting	Women	50%	88.0%	87.2%	64.7%	41%
		Men	40%	89%	87.2%	66.4%	58%
	Married couples discuss IUD as a FP method at the Holi festival, a festival of colors that symbolizes the joys of life	Women	41%	92.6%	87.8%	67.1%	42.5%
		Men	25%	85.8%	70%	79.7%	41.1%
NRHM	Medical tour of services and schemes, and ASHA as the link to the health system through the eyes of a medical student	Women	36.5%	91.3%	88%	63.4%	43.7%
		Men	41.9%	95.7%	84.5%	54%	38.5%
	A New Day, A New Sky: third person view of the reach and impact of NRHM on families	Women	29.2%	84.7%	83.6%	73.6%	43.1%
		Men	30%	93.4%	95.2%	81.1%	66.2%
	Celebrity couple promotes ANC, involvement of men in decision-making, and communication between husbands and wives	Women	26.6%	88.5%	86.7%	63.6%	44.1%
		Men	40.5%	78.1%	88.2%	72.4%	55.1%
	Celebrity Juhi Chawla promotes ANC and shares her personal experiences	Women	33.1%	88.2%	86.3%	68.4%	53.9%
		Men	35.3%	87.2%	88.9%	75.5%	47.8%

New Family Planning Mass Media Campaign

In 2009, the MOHFW requested renewed campaigns on FP, CH and MH, with emphasis on birth spacing. A three-phase mass media campaign for 2009-10 was designed to build on previous mass media messages, while outlining specific milestones for media creation and rollout on a quarterly schedule. Based on data from the NFHS-3 and the District Level Household and Facility Survey (DLHS) (2005-06), gaps in FP knowledge and behavior persist, including knowledge and use of modern contraceptive methods, birth intervals, and men's attitudes toward contraception. This mass media campaign aimed to reinforce IEC/BCC messages from 2005 through 2009, reach a broader audience with new messages, and address the most pertinent gaps in a systematic and consecutive way.

Strategic Approach and Objectives

Improve health of families by increasing knowledge and positively impacting attitudes and behaviors related to FP and RCH through mass media, and involvement of men in decision-making, in particular, re-position modern FP methods as health preserving and health promoting for mothers and children.

- Promote FP, with specific focus on birth spacing and postpartum contraception.

Audience

Primary (intended audiences varied with the communication theme)**:**

Message	*Audience*
Delaying the first birth	Newly married couples
Three years' spacing between children	Couples with at least one child
Postpartum use of IUDs	Couples who just delivered, or are about to deliver their child
Postpartum use - any contraceptive	Couples who have completed their families
Postpartum male sterilization	Couples who have completed their families, particularly men
Post abortion contraception	Couples where the woman has undergone an abortion

Secondary: Family elders

- Improve communication between husbands and wives, and involve men in decision-making.

Creative Approach

The FP campaign for 2009-10 places particular focus on birth spacing and postpartum FP, and repositioning BCC in the context of adopting modern methods for healthier mothers and children. This campaign called for the promotion of FP, especially spacing methods, among newlyweds and women with one child. There was also a need to promote FP methods other than female sterilization, which has been the most popular method adopted by women.

Participation of men in FP decision-making was a key objective of this campaign, which shifted the focus to men by highlighting their important role. All TV and radio spots had visuals and dialogues that encouraged men's participation in FP decision-making.

Some of the central creative approaches included:

- Interesting and memorable spots that normalized FP use through every day slice-of-life situations with emotional appeal
- Key roles for influencers
  - The husband and mother-in-law in larger roles
  - Presenting mothers-in-law, who have significant influence over FP decision-making, as role models
  - ASHAs, as the link between families and the health service system, in a mentoring capacity.

The Tag Line

'Pati patni karein vichar, swasth naari, swasth parivar'
'A happy and healthy family results when husband and wife are well-adjusted. When they are well adjusted, they talk between themselves and use the knowledge gained from health providers to plan their family.'

Interventions and Activities, and Duration

Campaign tag line

A tag line was developed, pre-tested and finalized for use as a common thread in all spots.

Phase I (July – December 2009)
Re-launching of all previously developed FP spots including 12 TV and 3 radio spots from USAID and UNICEF focusing on birth spacing, ANC, breastfeeding and newborn care

Phase II (January – March 2009)
Development and airing of four new TV spots and three new radio spots

Phase III (June – September 2010)
Development and airing of five new TV spots and four new radio spots

	PHASE II Message/Topic	Mass Media Spots	Creative Approach
	Delay age of marriage	1 TV spot 1 radio spot	Mard ki daad (The Mark of a Man) – A group of men discuss their 'Manly' deeds when one says he stood against his relatives who were forcing his under-age daughter to marry early.
	Basket of contraceptives	1 TV spot 1 radio spot	Animated video with a catchy song and modern visuals shares a range of contraceptives and their benefits.
	Delay first child	1 TV spot 1 radio pot	Aisi bhi kya jaldi hai (What's the Big Hurry!) – A newly married couple asks relatives who are pressuring them to have a baby, "what's the big hurry?"
	Use of contraception after abortion	1 TV spot	Nayi subah (A New Dawn) – A couple who recently had an abortion realizes they should have adopted a FP method to avoid the abortion, and ultimately chose to use an IUD to space their children.

	PHASE III Message/Topic	Mass Media Spots	Creative Approach
	Three years' spacing between children	1 TV spot 1 radio spot	Sahi Waqt Pe (At the right time) – Two men discuss everyday things that happen at the right time, such as the planting of seeds, and realize that the right time to have a child is three years from the last born.
	Postpartum contraception	1 TV spot 1 radio spot	Taiyaari Hamesha Pehle (Be prepared) – A husband tells his friend that it is better to plan and be prepared for things in life, and he and his wife have adopted PP contraception to plan their family.
	Postpartum IUD	1 TV spot	Fix It – An enthusiastic husband who fixes all his family's problems finds answers to spacing from an ASHA.
	Increased male sterilization	1 TV spot	Mujh Pe Chhod Do (I will handle it) – A husband who likes to handle his family's affairs decides to go for sterilization for the sake of their well-being.

Atmajaa TV Serial Drama

The *Atmajaa - Born from the Soul* serial drama developed and aired nationally on Doordarshan, addressed female feticide and dignity of girl children, and explored stigma associated with gender discrimination and inequality linked to HIV/AIDS. Many activities to introduce and increase awareness of these issues were carried out between 2001 and 2003, including a short film *Atmajaa* that was aired nationally, regionally, and in schools. On the strength of these activities, and following an evaluation of the film, a new strategy was developed and a pilot TV series *Atmajaa* was produced and aired. Based on the success of the pilot series that introduced the issues to audiences in an entertaining and informative way, additional episodes were produced and aired that reinforced and expanded upon the topics from the pilot series.

Strategic Approach and Objectives
Using an EE approach that allows audiences to have an ongoing relationship with compelling characters and storylines, introduce the issue of female feticide and other gender issues, and positively influence related knowledge, attitudes and behaviors.

Audience
Youth, married couples, and in-laws

Duration
13-episode series in 2004
52-episode series in 2005-06

The Creative Approach

Create characters that audience members can easily identify with and view as role models, and introduce themes and messages through the characters as they tell their stories in scenes from everyday life.

Interventions and Activities
Phase I (pilot): 13 episodes

- Presented issues of female feticide, gender inequality, and health and social well-being of girls.

Phase II: Episodes 1-26 of 52-episode series

- Connected viewers with characters as role models, introduced during the pilot series.
- Elaborated on issues presented during the pilot, and explored underlying factors in depth.
  - Themes included gender inequality, dowry, rape, female infanticide, women's rights, reproductive rights, property rights, domestic abuse, trafficking of women, sex selection and sex selective abortion, sexual harassment and the law.

Phase III: Episodes 27-52 of 52-episode series

- Part I (13 episodes) presented contemporary issues delving into mainstream health and family welfare problems at family and societal levels.
  - Focused on medical ethics, youth and adolescence, caring for elders, sexual harassment in the workplace, domestic violence, gender inequality, mother-in-law and daughter-in-law relationships, child sexual abuse and sexual abuse laws, female feticide, property rights, women's rights, sex selective abortion, and forced polyandry or bride selling.
- Part II (closing 13 episodes)
  - Targeted youth and focused on adolescent health, early marriage/ age at marriage, maternal health, institutional delivery, FP including birth spacing, government health schemes, and career and development opportunities.

Production Milestones

2004	Production of the 13-episode pilot *Atmajaa*	Produced by Plan International, and aired by MOHFW nationally, regionally, and internationally. Reports on female feticide gained global attention.
2004-05	Pilot series evaluation	The pilot had high television rating points among audiences, and insights for production of a new series were gained.
2004-05	Plan developed for a 52-episode series	MOHFW approved the plan and production began.
2005-06	Production of first 26 episodes	Aired nationally on Doordarshan and regional channels. Print and electronic media report on the series, increasing awareness of the drama and the issues.
2006	Production of final 26 episodes	MOHFW approved production and airing of the additional episodes.

Capacity Building

National IEC Workshop

The mid-term review of RCH-II in 2009 completed by GOI and development partners identified a need to sensitize and build capacity for health communication among IEC officials to strengthen programs and interventions. Recommendations from the review included regular meetings to share best practices among states, and capacity building for key principles of BCC. To help the NRHM meet its long-term goals and objectives, IFPS-II organized a national IEC workshop for MOHFW on RCH to enable better coordination and exchange of ideas between officials across government sectors.

Strategic Approach and Objectives

Build capacity and strengthen IEC staff for BCC intervention development and delivery through:

- Renewed dialogue between states and the national IEC department to share and learn from experiences of innovations and successful BCC campaigns
- Development of a more focused BCC activity plan for the following year's state Project Implementation Plans (PIPs)
- An understanding of the issues and challenges faced by state IEC officials in planning, implementing and monitoring BCC activities.

Audience
State level IEC Officers from across India, Communication Specialists from development partners, and IEC officials from MOFHW

Interventions and Activities
- Workshop agenda developed to address BCC for priority RCH areas.
- Special sessions facilitated by program heads of MH, CH, and FP, and various government media departments including the Directorate of Visual Publicity.
- Participatory sessions on Annual Media Planning, IPC interventions, and Innovative Media Options.

Duration
August 20-21, 2009

Results
- Representatives from 22 states attended, with 18 states sharing innovative IEC/BCC approaches and methods.
- Recommendation for more platforms similar to the workshop for discussion and mutual learning
  - Development by states of their PIPs with inclusion of BCC activities
    - Uttar Pradesh adopted this model for the 2010-11 PIP.

Advocacy

NRHM Advocacy Film

A 10-12 minute multimedia advocacy presentation was commissioned to showcase the initiatives, activities and achievements of the NRHM and outline their tasks heading up to 2012. The film was produced in English and Hindi for use at international forums and for key stakeholders.

Strategic Approach and Objectives

Increase awareness and recognition, and generate demand for the NRHM's services:

- Present the concept of the NRHM, its vision and objectives, the framework for the mission, the branding of health programs, specific interventions such as the ASHA, Janani Suraksha Yojana (JSY), Rogi Kalyan Samitis (RKS), and Indian Public Health Standards (IPHS).
- Share innovations and best practices across states such as the boat clinics of Assam that deliver health services to families along India's northern rivers, IPC/C interventions of Orissa and the intercommunication initiative of Jharkhand.
- Capture comments and testimonials from functionaries of the MOHFW, Government of India, and through state and field level interviews especially with ASHAs, and share the participatory approach of beneficiaries.

Audience

Key stakeholders at healthcare facilities and community level NGOs

Duration

Produced in 2007

Lessons Learned and Promising Approaches

Through the mass media campaigns and assessments, and TV serial drama employing an EE approach, the following key lessons were learned:

- The use of celebrities to promote BCC related to FP and RCH may not necessarily be more effective than employing other more traditional approaches such as the use of cultural symbols or traditions.
- Language and wording of messages, if not simplified for intended audience, may lead to low levels of recall and comprehension.
- Messages must be culturally and socially appropriate for the intended audience, and are improved through pre-testing.

The mass media campaigns and TV serial drama highlighted best practices for effective message recall and comprehension, and positive changes in knowledge, attitudes and behaviors.

- Reinforcement and expansion of messages over time and through various channels such as mass media and IPC improves recall and comprehension.
  - The importance of IPC was demonstrated through improved recall and comprehension of messages when aided or prompted.
- Creative and entertaining approaches to BCC, including the use of EE, effectively capture audiences' interest and attention, encourage social dialogue, and lead to positive changes in knowledge, attitudes and behaviors.
- A collaborative approach to developing capacity building and advocacy strategies with key stakeholders across multiple levels of the health system can lead to the integration of more effective BCC into existing programs.

What Works

- Creative, memorable and entertaining BCC
- Simple, culturally appropriate messages
- Reinforcement and expansion of messages over time
- Capacity building and advocacy strategies developed collaboratively with key stakeholders

SECTION 11

Behavior Change Communication

Uttar Pradesh

SECTION II

Behavior Change Communication

Uttar Pradesh

Behavior Change Communication: Overarching Strategy

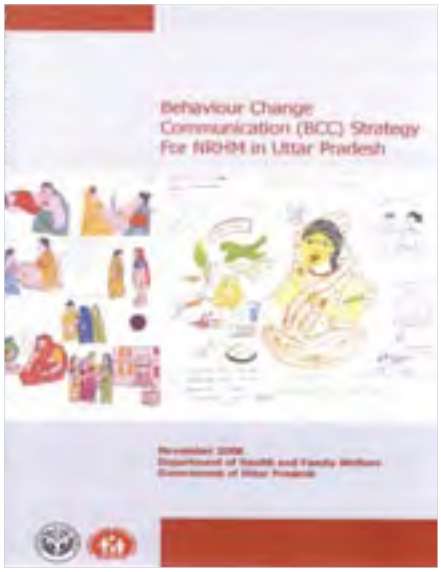
Development of the NRHM's BCC Strategy for UP

BCC Strategy for NRHM in Uttar Pradesh

Uttar Pradesh is one of the first states in India to initiate a state level BCC strategy for the NRHM. The BCC strategy was developed to provide a blueprint for focused interventions to achieve the NRHM goals. The strategy is evidence-based, and utilizes a major ancient Indian theory of communication known as *Sadharanikaran* in addition to the Pathways model from JHU/CCP. The document focuses on 14 priority behaviors for BCC through a multi-pronged communication approach including IPC and community events/ activities, community mobilization, and mass media.

Strategic Approach and Objectives

Improve health service delivery and outcomes through the development, orientation and delivery of a plan for strategic BCC addressing priority behaviors across 14 key health issues within all districts and across all levels of program delivery in UP.



- Address gaps in BCC strategy and capacity in the state:
  - Propose activities to close gaps in coordinated BCC efforts across and within national and regional programs.
  - Build capacity of healthcare program managers and frontline workers for integration with state mass media activities, and decentralization of BCC activity planning at the district, block and village levels.

Audience

All stakeholders at all levels working in UP under various health programs.

Interventions and Activities

- Develop and deliver a BCC strategy for the NRHM in UP that identifies priorities for improving health across populations through integration and coordination of activities, and adaptability at district, block and village levels. The document is broken into key sections:
  - Situation analysis of health in UP
  - Selection of priority behaviors and barriers analysis
  - Overarching BCC strategy for interventions and innovations
  - Plans for short-term BCC interventions
  - Plans for long-term BCC interventions
- State level roles and responsibilities
- District level roles and responsibilities
  - BCC guidelines for implementation
  - Building BCC capacity among health program managers
  - Supportive supervision, monitoring and evaluation
  - Recommendations and conclusions.
- Develop and deliver a guide for implementing BCC activities outlined in the state strategy at the district, block and village levels through program health managers and frontline workers.
- Design a model for orientation, training, and capacity building of district, block and village level functionaries to integrate BCC activities from the state strategy with annual PIP.
  - Inclusion of a cascade training component for master trainers to build capacity for BCC activity integration with PIP in all districts of UP.
- Delivery of a training of trainers (ToT) capacity building workshop for key district and block level functionaries to train master trainers for cascade trainings throughout UP.

Duration

November 2008 and ongoing

Results

- The *BCC Strategy for NRHM in Uttar Pradesh* was delivered to the Government of UP, and has been adopted at the state level.
- A model for capacity building ToT and subsequent cascade trainings was developed and delivered to the Government of UP, and has been deployed at the district and block levels.
- The capacity building ToT program was delivered and included two participants from each district (District Community Mobilizers (DCMs) and District Health Education Information Officers (DHEIOs)/ Deputy DHEIOs) for a total of 33 districts and 69 participants (in Allahabad regional workshop) and 38 districts and 73 participants (in Agra regional workshop). Overall, 71 districts in UP were covered and 142 participants oriented through the Soch se Amal tak! Workshops.

Development of NRHM's BCC Implementation Guide for UP

From Awareness to Action – A Guide for District and Block Level Functionaries to Implement Behavior Change Communication Programs

A guide was developed for district and block level health program managers to guide implementation of the BCC activities outlined in the state's strategy.

Strategic Approach and Objectives
Provide a 'hands-on' guide to district and block level managers responsible for implementing BCC activities in their communities through an abridged version of the strategy document that:

- Provides clear guidance and direction on how to mobilize, implement, and monitor activities in the field.
- Provides supporting and monitoring tools for implementation in the field.

Audience
BCC functionaries at district and block levels – DCM, DHEOs, HEOs and BPMs

Duration
January 2010 and ongoing

Results
The guide was distributed to district and block level functionaries at capacity building workshops in Allahabad and Agra, and will be distributed to other districts through capacity building workshops to ensure widespread coverage and use.

Capacity Building

Development of the ASHA Newsletter

Under the NRHM, ASHAs have been selected from their village to create awareness on priority health issues, to promote and mobilize better healthcare planning and healthcare seeking practices, and increase utilization and accountability of existing healthcare services. Capacity building for ASHAs is seen as a continuous process going beyond initial training in order to ensure they are equipped with accurate and timely information, and well-honed skills.

Communication for, about, and between ASHAs was deemed important to continue the capacity building process, and to further enhance ASHAs' knowledge and skills to deliver BCC. Over 130,000 ASHAs work in UP, and present a significant opportunity to disseminate effective messages for priority health behaviors if they are continually trained, informed, motivated and empowered. A 12-page newsletter known as *Ashayein* was created to take advantage of this important communication channel.

Strategic Approach and Objectives

- Build capacity of ASHAs continually by increasing the use and dissemination of regular, accurate and up-to-date information to improve health service delivery and outcomes in UP.

- Create a forum for bringing together ASHAs, position the role as a skilled deliverer of quality and timely healthcare information within the community, and recognize ASHAs as an identity.
- Provide solutions to issues faced by ASHAs to enhance their counseling skills.
- Serve as a motivational tool by recognizing evidence-based work of ASHAs, encouraging them to share their stories and experiences, and act as a source of inspiration to others.

Audience

ASHAs working in UP

Interventions and Activities

- Completion of an informal needs assessment through field visits with ASHAs.
- Formation of a core group of subject matter specialists from the Government of UP, SIFPSA, and IFPS-II.
- Development of a conceptual framework for a newsletter through a participatory process, pre-tested with ASHAs through individual interviews and focus groups for comprehension, retention, appeal, likeability, overall impact, and intention to respond.
- Production and printing of the *Ashayein* newsletter.
- Development of a distribution system for the newsletter through Chief Medical Officers (CMOs) in each district who then distribute it to ASHAs.

Duration

Quarterly beginning with the July-September 2008 issue

Results

- More than 800,000 *Ashayein* newsletters have been distributed to 170,000 ASHAs between July 2008 and June 2009.
- A rapid assessment of ASHAs carried out in Sitapur and Barabanki revealed that *Ashayein* had high likeability, comprehension, and usefulness among ASHAs.
- An impact assessment of 158 ASHAs revealed that many ASHAs relied on *Ashayein* for sharing information with their communities; this was reinforced through qualitative interviews with ASHAs during field visits.
- Hundreds of ASHAs have submitted content to the newsletter to date.

Distance Learning Program

While frontline health workers in UP are trained in technical skills, they display a low self-image, and perceived lack of appreciation for their role by their community. The need to build community and systemic sensitivity towards grassroots service providers, and facilitate an environment where quality health services are perceived as a right by the community remains a key challenge of communication. Radio presented an opportunity to increase knowledge, and improve skills critical to the effective dissemination of BCC messages by local healthcare providers.

Strategic Approach and Objectives

Through the reach of radio, improve knowledge and skills of frontline healthcare providers such as ASHAs and ANMs:

- Increase knowledge about health issues including FP, reproductive tract infection (RTI), sexually transmitted infection (STI), HIV/AIDS, MH, CH, and age at marriage.
- Build IPC skills by demonstrating enhanced client-provider interactions through representative characters and radio role plays.
- Motivate and empower frontline health providers by instilling in them a sense of pride and self-respect.

Audience

ASHAs and ANMs

Interventions and Activities

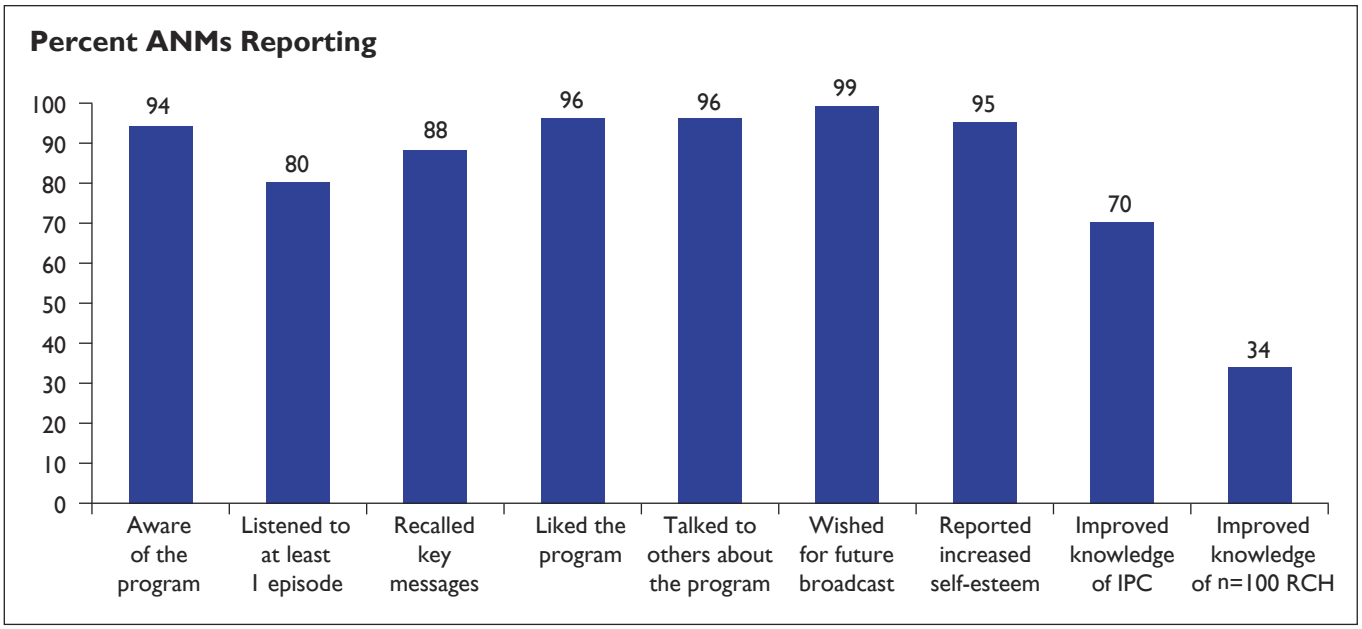
- Development and airing of a 26-episode radio educational program addressing health issues, myths, misconceptions, and good healthcare seeking behaviors
  - Episodes talk of FP and contraception issues, maternal and child health, and effective IEC and IPC skills.

Duration

2004-07

Key Messages

- ASHAs and ANMs are valuable to the community, and contribute to the health and well-being of families.
- They should be proud of their work. Continual learning will instill pride and confidence.



Results

Through a qualitative assessment of ANMs in five blocks of Jhansi district, the radio distance learning program was found to have high levels of listenership, comprehension and appeal, and increased knowledge specifically in IPC and RCH.

Mass Media

Radio Drama Series

Radio is an important component of mass media with a wide reach across rural UP, thus, offering a unique media edge most importantly with rural audiences, the largest and most critical audience for the IFPS-II communication effort. In fact, more women and men in UP are exposed to radio than in India overall (NFHS-3).

UP has high maternal mortality, lack of institutional delivery, and high rates of RTIs and STIs. There is also a large gap between awareness (95%) and use (27%) of modern methods of contraception (NFHS-3). Reasons for low and inconsistent use of contraception vary; among them include myths and misconceptions about contraceptive methods, presenting the need for a medium to convey correct information about health services. Radio was used to disseminate BCC messages to the general population through a drama series.

Key Messages

- Women and men alike have the right to good health.
- A happy family is a small, healthy and planned family.
- A planned family improves health, education, and quality of life.
- Couples should plan their family size and health together with the help of a healthcare provider when needed.

Strategic Approach and Objectives

Using an EE approach, through representative and compelling characters and storylines:

- Increase knowledge and dispel myths and misconceptions about health issues including FP, RTI, STI, HIV/AIDS, MH, CH, and age at marriage.
- Present role model couples discussing FP.
- Motivate and empower responsibility and action for healthcare.

Audience

Rural men and women of reproductive age and their families, and local community leaders.

Interventions and Activities

Development and airing of a 26-episode radio drama series addressing health

issues, myths, misconceptions, and good healthcare seeking behaviors:

- Episodes address the well-planned family, value of a girl child, importance of delayed marriage, male involvement in decision-making, and male involvement in caring for women and children.

Duration
2004-07; 2008

Results

- Demand for the first radio drama series was high, and led to the development and airing of a second 26-episode radio drama – *Sunehre Sapne Sanwarti Rahein* (2008) – expanding upon messages of the original series.
  - Issues addressed included the role and contribution of ASHAs and ANMs to the health and well-being of communities, nutrition, hygiene, immunization, gender issues, and population stabilization.
  - Aimed to create awareness and generate demand for JSY.
- A mid-term evaluation revealed high popularity and positive feedback on the series, a desire of listeners for a similarly-based TV series, and message dissemination through multiple channels including print and electronic media.

Multi-media Female Sterilization Campaign

The XXXVIII PAC held in January 2004 recommended the promotion of female sterilization through a multi-media communication campaign to increase uptake. The project envisaged development and implementation of a BCC campaign aimed at positively impacting attitudes of and behavior for female sterilization. Accordingly, a BCC package was developed for UP.

Strategic Approach and Objectives

Through a coordinated multi-channel communication approach:

- Increase knowledge of female sterilization.
- Improve attitudes and motivate behaviors for female sterilization.

Audience

- Couples 25 years and older with an unmet need for sterilization and their families
- Influential community leaders
- Healthcare service providers

Interventions and Activities

- Develop and pre-test a package of BCC campaigns through a wide range of channels including radio, TV, folk performances, wall paintings, hoardings/billboards, posters, and cinema slides.
- Deliver the mass media campaign across the state, and local media campaign in 33 focus districts.
- Creative package includes:
  - TV Films – Two films in Hindi
    - Camp Film (60 sec and 30 sec)
    - Teej Film (40 sec and 30 sec)
  - Radio Spots – Five separate spots in Hindi
    - Camp Spot (60 sec)
    - Teej Spot (40 Sec)

Key Messages

- Promote usefulness and ease of female sterilization.
- Address post-operative complication.
- Promote sources of services.

    - ANM Behenji Spot (60 sec)
    - Saas Bahu Spot (60 Sec)
    - RCH Camps Spot (60 Sec)
- Poster – Bilingual Poster
- Wall paintings
    - Doctor Visual Theme
    - 'Woman with Pot' Visual Theme
- Hoardings
    - Doctor Visual Theme
- Cinema Slides

Duration

First Round – May to August 2006

Second Round – June to September 2007

Results

- In the first round of the campaign, 25 TV spots and 2,304 radio spots were aired; 43,150 posters were printed and distributed; 411 hoardings and 66 glow signs were installed across 33 IFPS-focal districts; and 1,126 folk performances were organized in 33 IFPS-focal districts.
- During the second round (mass media focused), 647 TV spots and 2,146 radio spots were aired, in addition to the release of 260 newspaper ads in a number of leading regional dailies.

Multi-media IUD Campaign

Suvidha IUCD Campaign

Strategic Approach and Objectives

- Generate demand for intrauterine contraceptive device (IUCD) by:
  - Addressing the prevalent myths and misconceptions
  - Creating brand positioning and a visual identity for the newly launched Copper-T (CuT 380 A)
  - Positioning CuT 380A as a trouble free, reliable, clinic-based method of contraception providing protection from unwanted pregnancy for up to 10 years
- Upgrading the counseling and IPC skills of service providers.

Audience

- **Primary Audience**
  - Women 25-45 years having one or more children wanting to either space or limit family size
- **Key Influencers**
  - Husbands
  - Mothers-in-Law
- Service Providers

Interventions and Activities

- Branding
  - Brand name 'Suvidha' means convenience.
  - Preferred logo design of the two flowers and two leaves was found to be very appealing and connoted 'Khushali' or a feeling of well-being to the target groups.
  - Two flowers represented two children and the leaves were the caring parents.
  - Promote preferred benefits of convenience and protection from unwanted pregnancy.
- Communication Activities
  - Mass Media
    - Television
    - Radio drama series for general public
    - Distance Learning Program for service providers
  - IPC
    - Counseling and follow-up card for beneficiaries
    - Counseling tools for service providers
    - Job aids for ANMs
  - Local and mid-media
    - Posters, banners and tin plates
    - Wall paintings and hoardings
    - Folk performances

Duration

January – April 2007

Advocacy and Skill Building

NRHM Flipbook for ASHAs

With the establishment of the NRHM in 2005, an emphasis was given to health among rural populations. A need was felt to broadly communicate the NRHM's mission and goals, health focus areas, and schemes of the government to populations it served. Through IPC and group meetings, ASHAs have a wide reach among populations targeted by the NRHM, and presented an opportunity to broadly and effectively communicate the NRHM's messages to members of the community.

Strategic Approach and Objectives

Provide ASHAs with a visual tool to facilitate group meetings that:

- Promote the NRHM mission and goals, address health issues highlighted by the NRHM, and government services available.
- Facilitate talks on topics learned in the ASHA training.
- Deliver effective IPC on FP, MH, CH, and RH.

Audience

Community members receiving services from ASHAs

Interventions and Activities

Development of a flipbook for ASHAs to use during group meetings covering key issues of the NRHM; the flipbook

included six sections:

- Overall health and sanitation
- MCH including ANC
- HIV/AIDS
- FP
- Adolescent health
- NRHM programs such as vaccines and disease prevention, and vitamin A and iron supplements

Produced

2007

Results

- 129,450 flipbooks produced and distributed to ASHAs in 71 districts.

Needs Identified

- Information gap between:
  - Service providers and clients
  - Policymakers and communities.
- Need for a participatory and inter-sectoral approach to healthcare.
- Need to employ the NRHM's goal of assisting society to articulate its health needs, and provide a role in its management.

- ASHAs found the tool very useful, and indicated that additional information in this same format on mental illness, including depression, psychosis and schizophrenia was desired.

Sensitization of PRI Leaders

Health services for women and children in rural areas have traditionally depended upon inadequate health infrastructure and under-supported service providers. Contributing to the poor status of health services in the state are a lack of inclusion of local stakeholders, low awareness of development and health indicators, low awareness of rapid population growth and its effect on overall development, and provider driven services.

SIFPSA recognized the need to improve community involvement in program implementation and set forth a strategy to sensitize political leaders and communities on MCH and the NRHM.

Strategic Approach and Objectives

- Improve knowledge and build capacity for FP and RH BCC through local, district, and state level political, social, and community leaders.
- Improve knowledge and build capacity for availing and managing need-based health services.
- Involve the community in sharing responsibility for their own health.

Audience

- Policymakers, political leaders, social representatives, influential community members, and officials of health and development departments at district and block levels across 33 districts

Duration

July – September 2007

Interventions and Activities

Key district and block level healthcare functionaries and stakeholders across 33 districts were invited to one-day workshops where they were sensitized on the current health situation in UP, and the NRHM's vision, government policies, and programs relating to MCH.

- Program Management Units (PMUs) organized and facilitated FP and RH sensitization workshops for influential members of the community with support from local government and NGO leaders to:
  - Share health indicators of districts across UP, and UP overall.
  - Involve stakeholders in developing action and implementation plans to improve availability and management of appropriate health services based on situational analysis.
- Distribute a brochure with messages from the Chief Minister, Minister of Family Welfare, and SIFPSA Chairman and Executive Director.
  - Messages provide support for administrative and managerial responsibilities of health services at the community level.
- Distribute a booklet developed specially for the PRI representative: "Jan Chetna Abhiyan – ek Swastha Pradesh ki ore" (Community Awareness Movement – towards a healthy state).
- Implement a "follow-up card" system for local contributions to health services, administrative and managerial processes.

Results

- District level workshops successfully held in 32 of the 33 focus districts, and sensitized 4,814 stakeholders.
- After district level sensitization workshops, block level workshops were organized within 32 districts; 396 out of 404 blocks held workshops (97% coverage). Messages providing support to community level health services management were distributed to all stakeholders at this time. For each district/block level workshop, authorities provided certification.

Mid-media

Comprehensive Poster on Family Planning

Aao Batein Karein

Following a previously successful FP program, *Aao Batein Karein*, a comprehensive poster was created expanding on health information from a previous poster.

Strategic Approach and Objectives

Inform and educate men and women about:

- Contraception options available to them at clinics and from community health workers.
- Maternal, newborn and child health services available to them at clinics and from community health workers.

Audience

Single men and women of reproductive age, and couples with unmet need for family planning

Interventions and Activities

- Develop a comprehensive poster on FP products and services; and maternal, newborn and child health services.
- Place posters in visible locations:
  - Public and private health clinics
  - Women's hospitals
  - Urban family planning centers and health facilities
  - Panchayat Ghar
  - Anganwadi centers.

Produced

2006 and 2007

Results

162,767 posters were placed in targeted locations: healthcare facilities at sub-centers, community health centers (CHCs), and primary health centers (PHC) across 70 districts of UP.

Community Mobilization

Kumbh Mela

Kumbh Mela is a significant religious event held every four years that attracts millions of people from all over India from different religions to partake in ceremonial holy bathing. The crowd that gathers at the mela site is a mix of people from all segments of society and from all age groups, including people with unmet need for FP, decision-makers in families, and influencers in communities who can be instrumental in bringing about necessary change in attitudes and behaviors of people towards FP. The mela provides an immense opportunity for SIFPSA to reach out with a cross-section of health messages at one place. The exhibition also offers the potential to use a mix of different media, including local media to convey messages effectively to a captive audience.

This platform had successfully been used by SIFPSA in 1995 in Allahabad, 1998 in Haridwar, and again in 2001 in Allahabad, and drew very large audiences. The 2007 event presented another opportunity for SIFPSA to utilize a proven method to disseminate health messages to intended audiences.

Strategic Approach and Objectives

Through audience analysis and community mobilization, disseminate messages about FP and RH to a captive audience through

Key Messages

Theme: Healthy and Happy Families

- Law supports delaying marriage until after 18
- Educate girls
- ANC for pregnant women
- Institutional deliveries
- Immunizations for children
- Postnatal care
- Health of women and babies improves economic opportunities for family
- Copper T380A
  - For desired family size
- Small family has benefits
- Small, healthy family leads to more prosperity.
- Men should participate in FP decision-making

Kumbh Mela, and generate demand for FP and RH products and services.

- Using a mix of media including community level (folk media), mass media (video), and IPC (counselors), reach those who may not otherwise be reached with health messages.

Audience

Literate and non-literate, and urban and rural men and women across UP and India

Interventions and Activities

- Kumbh Mela exhibition
  - SIFPSA Pandal with a stage and scene, hosted folk performances delivering BCC messages.
  - IEC panels communicated BCC messages.
  - Doctors counseled community members on client-centered FP issues and opportunities.
  - IEC/IPC materials were developed and disseminated to community members by counselors and doctors.
  - Flipbooks were utilized by counselors and doctors to convey information and educate community members.
  - Free contraceptives were provided to interested community members.

Duration

January – February 2007 (the event lasted 45 days)

Results

- SIFPSA estimates around 2,000 people visited the SIFPSA Pandal every day for each of the 45 days, thus, the messages spread to an estimated 90,000 to 100,000 people.
- The activities increased awareness and educated individuals on FP and healthy families, and generated demand for FP and RH products and services.

NGO Projects
(street plays, and puppet and magic shows)

Folk performances are a popular form of entertainment in rural areas across India. Popular folk styles can be an effective platform, and folk troupes with experience in these styles can help convey messages to audiences with high impact. Five popular folk styles that provide a platform for the integration of FP messages include:

- Nautanki (folk theatre)
- Qawwali (traditional songs in Urdu)
- Puppetry
- Alha and Birha (traditional ballad singers)
- Magic.

Strategic Approach and Objectives
Through these popular folk styles and experienced folk troupes, train troupes to deliver effective FP BCC to captive audiences.

Audience
Rural communities

Interventions and Activities
Develop and deliver workshops to uniformly and rigorously train selected troupes in developing scripts that integrate FP BCC messages.

- Orient troupes on the objectives of the SIFPSA project.
- Sensitize them to the nature of the messages.
- Host interactive sessions to finalize scripts that integrate FP messages.

Duration
1999 – 2007

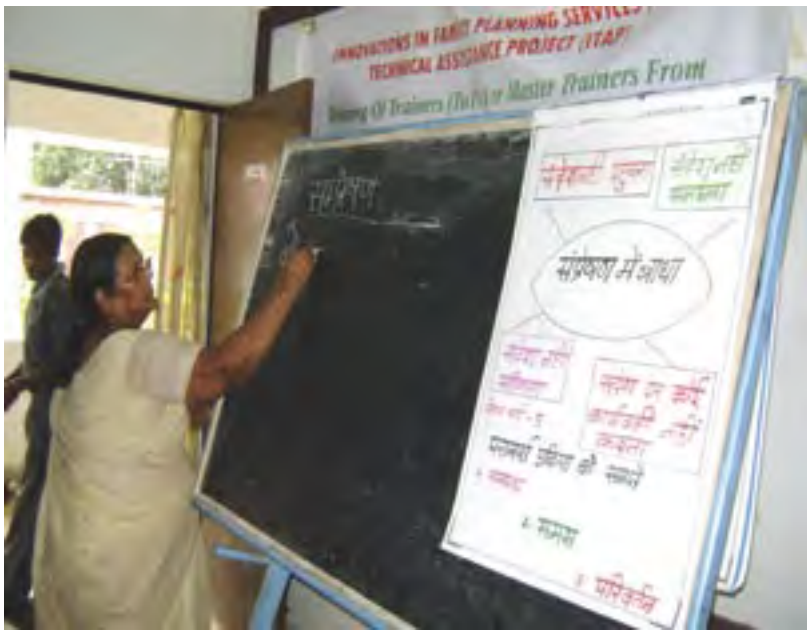
Results

- SIFPSA conducted six training workshops since 1999.
- In January 2007, 76 professional folk troupes were trained in all five forms of folk media.
- The performances have been rewarding for NGOs and cooperative agencies involved as platforms to disseminate their project objectives. Following performances, inquiries from audience members poured in, helping achieve objectives of taking FP to the doorsteps of families. This activity has been a major success with demands for more performances.
- Folk performances also proved useful in promoting the local community health worker and the services offered by her, and have effectively carried FP messages to rural populations.

Interpersonal Communication

Family Welfare Counselors Training Module and Flipbook

Family welfare counselors (FWCs) are placed at government health facilities under the NRHM to provide counseling to families on social and health issues, and provide a unique opportunity to expand FP and RCH messages through community workers.



Strategic Approach and Objectives

Strengthen health messages delivered to families by frontline workers during in-house visits through enhanced counseling skills and job aids of FWCs in the areas of FP and postpartum FP, ANC, PNC, immunization, and nutrition.

Audience

Training Manual – Trainers of the FWCs
Flipbook – FWCs and their clients

Duration

September 2009 – December 2009

Interventions and Activities

- Strengthen counseling skills of FWCs through the use of a training manual on effective BCC.
- Provide FWCs with a flipbook that makes it easy for FWCs to disseminate BCC messages.

Results

The training module was reviewed and piloted by FWCs, and will be used by the State Institute of Health and Family Welfare (SIHFW) for regular trainings of FWCs.

IPC Tools for Saloni Swastha Kishori Yojana

Saloni Swastha Kishori Yojana (SSK Scheme) is a government scheme for adolescent girls designed to decrease anemia levels through the provision of iron and folic acid (IFA) tablets and de-worming. The scheme provides a unique opportunity to leverage an existing platform for the integration of BCC, and bring about sustainable health behavior change in adolescent girls.

Strategic Approach and Objectives
Through IPC between teachers and adolescent girls, IPC tools, and structured group meetings, introduce specific nutrition and RH themes that motivate girls to adopt healthier behaviors.

Audience
Teacher's Training Manual/Teacher's Flipbook – School teachers of Saloni Schools (where scheme is being implemented); *Saloni Diary* – School going adolescent girls

Duration
2009 – 2010

Intervention and Activities
- Create a teacher's training manual with 10 curricula on RH and nutrition.
- Create flipbook to instruct adolescent girls on various health topics related to anemia and anemia prevention.
- Train master trainers to facilitate teacher training on delivering Saloni sessions on health topics.
- Train teachers to deliver Saloni sessions, and conduct Saloni Sabhas, or group meetings in schools.
- Deliver Saloni health sessions in schools, and conduct monthly Saloni Sabhas for interactive and open discussion about health topics.
- Provide girls with a Saloni Diary for them to keep track of their nutrition and eating habits.

Results
A pilot phase of implementation began in 2009 in select communities in Haridwar, with completion expected at the end of 2010. The Government of UP accepted the campaign and associated materials, and will be implementing it at the state level in 2010-11.

Leveraging Public-Private Partnerships

Social Franchising Scheme

Social franchising is one of the major PPP models undertaken by SIFPSA in UP. The Hindustan Latex Family Planning Promotion Trust (HLFPPT) was selected as the franchiser for this project and has set up franchisee hospitals under the brand "Merry Gold" across UP districts, "Merry Silver" at the block level and "Merry Tarang" referral networks at the village level. This network of private hospitals provides quality RCH services to both urban and rural poor populations at low or competitively priced rates.

HLFPPT aims to establish as part of "Merry Gold Health Network", 70 fully franchised "Merry Gold" hospitals at the district level, 350 partially franchised "Merry Silver" clinics at the block level, and 10,500 referral agents as "Merry Tarang" at the village level in 35 UP districts.

Services include:

- Merry Gold Hospitals
  - Emergency obstetric care services
  - Skilled delivery
  - FP counseling and products including IUD insertion
  - Ultrasound and laboratory services
  - Ambulance availability
- Merry Silver Clinics
  - Skilled delivery
  - FP counseling and products including IUD insertion

    - Emergency obstetric care referral services
    - Immunization
- Merry Tarang Services
    - Promotion of FP/RH products and services, and referral to clinics or hospitals
    - FP counseling
    - Immunization

The need exists to increase awareness among community members and generate demand for services through the Merry Gold Network of providers.

Strategic Approach and Objectives
Through social marketing, develop and promote a brand of standardized, quality services across the Merry Gold Network.

Audience
Urban and rural poor populations in need of low cost FP and RH products and services

Duration
2007 – 2010

Interventions and Activities
Increase the availability of condoms and oral contraceptive pills (OCPs) in nearly 44,000 villages with populations between 1,000 and 5,000:

- Increase condom sales in rural UP from 132 million pieces to 152 million pieces.
- Increase OCP sales in rural UP from 2.69 million cycles to 2.82 million cycles.
- Ensure that at least one retail outlet stocks oral pills and condoms in 50 percent of villages with populations between 1,000 and 5,000.

Over the course of the first two years of the program, more than 13,000 Market Town Activities were conducted, reaching 945,000 men and nearly 315,000 women. Around 21,300 community meetings were conducted, with another 145 community-based distributor (CBD) meetings that were attended by more than 4,000 community-based CBDs.

Results

- Retail outlets in rural villages are willing to stock condoms and pills if the products are made available to them.
- Both condoms and pills are available in at least one retail outlet in nearly 58% of villages.
- Number of retail outlets stocking condoms is higher than those stocking OCPs.
- Innovative approaches to mid level IPC such as market town activities strengthen both supply and demand.
- IPC is essential for consistent and correct messages on usage of products and management of side-effects, especially for pills.

Lessons Learned and Promising Approaches

The comprehensive approach employed in UP to increase awareness and generate demand for improved health required a high level of coordination and support from stakeholders at all levels. While the comprehensive strategy and implementation plan was effective at improving the availability and delivery of healthcare services across the state, decentralization was also found to be helpful.

- Health functionaries in far reaching corners of the state are reliable, credible, and sometimes the only source impacting health of their communities.

What Works

- Overarching strategy
- Capacity building across all levels of strategy implementation
- Inclusion, collaboration, and participation across all functions
- Reinforcement and expansion of messages
- Disseminating messages across multiple mediums to captive audiences through institutionalized events:
  - Mass media
  - Community folk media
  - IPC and counseling

- ASHAs may deliver the only healthcare men and women will receive in the most remote parts of UP, and must be well-trained and provided with adequate resources to make an impact.
- PRI Leaders may be the most effective influencers of health policy in their communities if they are sensitized and trained in the status of health in their districts, and resources are made available to them through national or state level schemes.

The development of BCC visual aids such as toolkits and flipbooks, and distance learning radio programs was found to be very useful for educating healthcare workers, and

disseminating health messages to community members. Additionally, UP's close-knit communities and its population committed to improving health, can effectively be mobilized to improve the situation under an overarching and broad-based strategy and implementation plan. The following were key to the project's success in UP:

- Develop an overarching BCC strategy for all levels of administration within the healthcare sector through collaboration and participation.
- Build capacity for synergistic BCC, program design, and implementation across all levels of service delivery – national, state, and local; and among families, communities, and facilities.
  - Through events such as workshops and tools such as informative flipbooks.
- Scale programs and increase reach through expanded capacity building efforts, and participatory BCC tool design and deployment.
- Brand and promote products and services from healthcare resources to communities, such as ASHAs or Merry Gold Network franchisees.
- The Kumbh Mela event was again effective in reaching large audiences in cost-effective ways through proven BCC platforms such as folk media and IPC.

SECTION III

Behavior Change Communication

Jharkhand

SECTION III

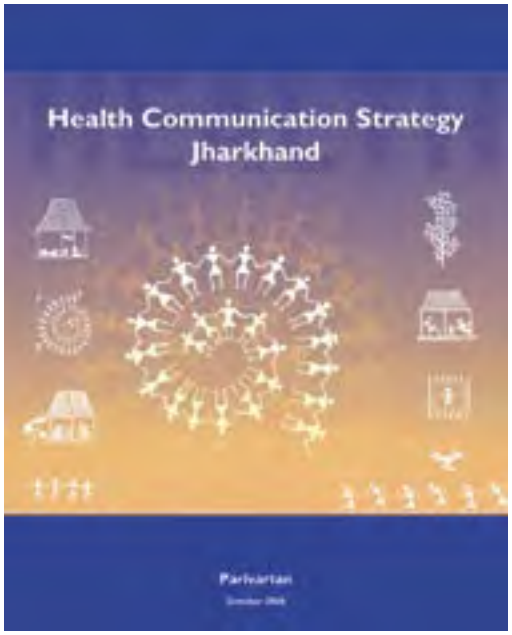
Behavior Change Communication

Jharkhand

Behavior Change Communication: Overarching Strategy

Development of the Jharkhand BCC Strategy

The role of strategic communication is critical for the NRHM to achieve its objectives in Jharkhand, and they recognized the need to move from an event-oriented and isolated approach for addressing health issues, to a collaborative and comprehensive approach. A comprehensive strategy that addressed priority health areas through an integrated and multi-channel BCC approach was needed to improve health and impact infant mortality, maternal mortality, and fertility rates in the state.



Strategic Approach and Objectives

Develop a comprehensive BCC strategy for priority health areas to:

- Enhance awareness, generate demand and facilitate behavior change in specific target populations for health services related to FP, MH, CH, HIV/AIDS and adolescent reproductive and sexual health (ARSH), to improve indicators of IMR, MMR and TFR.
- Build trust in and improve the image of the health system, by increasing the IPC skills of providers through training and capacity building, and by creating linkages between the private and public sectors to ensure quality of services.
- Create an enabling and supportive environment through community-based dialogue, advocacy, and social mobilization.

Audience

Primary

Men and women of reproductive age

Secondary

Parents, community leaders, faith leaders, health service providers, traditional healers, local governance bodies, private sector practitioners

BCC Strategies for Jharkhand

- Integrate mass media with community level media and IPC activities to increase the Opportunity to See (OTS) of the health campaign.
- Use of radio for specific health messages to ensure maximum reach in a cost-effective way.
- Extensive use of IPC and mid-media in rural and hard-to-reach areas.
- Leverage existing social networks, festivals and cultural practices to disseminate health information more widely.
- Identify existing supply points such as chemist outlets, PHC and cinema halls to reach large numbers of people with reminder health messages.

Interventions and Activities

The *Parivartan* (Change) BCC strategy was developed by IFPS-II, USAID, and leadership from the Jharkhand Department of Health, with inputs from all stakeholders working with the state under various health programs.

- A situational analysis identified the current health scenario, IEC efforts, and gaps to gain insights on the issues faced in the state.
- Participants and stakeholders worked in groups through two workshops to develop a BCC matrix and identify primary and secondary audiences, underlying social barriers, and the tools and channels recommended to achieve desired outcomes.
  - A development workshop initiated by the Health and Family Welfare department and supported by IFPS-II using the results-oriented framework was held in Ranchi in March 2007 to:
    - Explore the role and importance of evidence-based strategic communication.
    - Prioritize health areas to be addressed.
    - Identify barriers to the adoption of health behaviors and promising interventions.
  - An implementation planning workshop was held in May 2007.
- A strategy framework was proposed to work as a blueprint guiding IEC/BCC campaigns and efforts for the state and its partners. Strategies for focused and targeted interventions under FP, MH, CH, HIV/AIDS, and ARSH were identified.
- Monitoring and evaluation implementation plan was drafted.
- Various levels within the Government of Jharkhand, IFPS-II and USAID provided inputs and revised the communication strategy for the development of a final document.

Print Date

October 2008

Results and Key Recommendations of the BCC strategy

The Health Communication Strategy for Jharkhand, Parivartan was formally launched on November 18, 2008 by then Health Minister Shri Bhanu Pratap Sahi. Ms. Monique Mosolf, Chief Reproductive Health Division, USAID was also present.

The BCC strategy recommends the following nine activities:

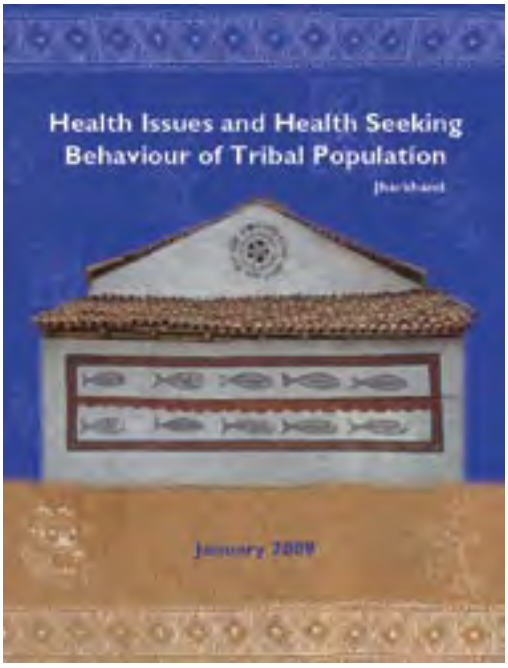
1. Conduct a BCIS for developing baseline indicators and formative research across a broad range of health issues for developing communication concepts.

2. Conduct an assessment of different media outlets available in the state, including mass media, in order to understand the reach of different channels.
3. Finalize the development and implementation of two integrated multi-media campaigns on birth spacing and MH.
4. Initiate PPP models for introduction of new contraceptives, such as SDM and DMPA in the state.
5. Develop and implement IPC training protocols, manuals and materials for health providers to support IPC and group sessions on prioritized health issues.
6. Identify and ensure visibility at both public and private health facilities about the availability of immunization services.
7. Initiate PPP models on prioritized adolescent health issues.
8. Develop capacity of health providers to provide information and counseling to adolescents.
9. Introduce a telephone helpline to disseminate information on HIV/AIDS and other priority health issues.

Addressing Needs of Special Populations

Health Issues and Health Seeking Behavior of Tribal Populations Document

Jharkhand is home to over 30 tribes that make up 26.3% of the total state population (Census of India, 2001). There is a strong need to identify information gaps in health practices and service utilization of Jharkhand's tribal population as there have been constraints in addressing their requirements through effective policy measures and service delivery programs (Health Issues and Health Seeking Behavior of Tribal Populations, January 2009). To improve health service utilization among these populations, it was important to identify barriers to access that were unique to these tribes, and cultural and social factors that could aid in reducing barriers and increasing access. The Government of Jharkhand in collaboration with IFPS-II wanted to understand behaviors, rituals, beliefs, and remedies related to RCH followed by the Santhal, Munda, Oraon, and Ho tribal groups in the Santhal Pargana and South Chotanagpur regions, and better understand the interplay between the physical and political environment within these select tribal groups.



Strategic Approach and Objectives

Identify, understand and analyze existing health seeking behavior of couples in major tribal groups with a focus on the traditional system of healing, through a comprehensive qualitative assessment.

Objectives of the Assessment

- Identify the key behaviors, traditional rituals, beliefs, practices and remedies followed during critical stages related to health and disease.
- Assess the knowledge level, utilization, and traditional practices related to contraception.
- Identify treatment seeking behavior during pregnancy, delivery, and post delivery period.

- Examine the rituals and practices related to newborn care and breastfeeding.
- Identify the beliefs and perception about RTI/STI issues.
- Identify existing healing rituals, perception about the existing health system, the role of indigenous medicine among the tribal population, and integration of traditional medicine with the prevailing RCH program among the traditional service providers, and providers from the mainstream health system.

Audience

All stakeholders at all levels working in Jharkhand under various health programs.

Interventions and Activities

A qualitative assessment was conducted and a final report produced that identified underlying barriers of geographic access, economic constraints and cultural issues to be addressed in order to improve health service utilization.

- Samples were drawn from Santhal, Munda, Oraon and Ho tribes, and a minority tribe, Pahariya, and unique tribal characteristics and differences were documented.
- Social mapping was carried out to list resources and utilization of services.
- Force field analysis, listing and pile sorting for perception of health system and treatment seeking behavior was completed.
- Key informant interviews were conducted with:
  - ANM, AWW, and traditional birth attendant (TBA)
  - Local registered medical practitioners (RMPs), who practice in the villages
  - Village-based traditional healers.
- In-depth interviews were conducted with:
  - At least one woman/couple with experience of neonatal death
  - At least one respondent with experience of maternal disease or death in the household.
- Focus group discussions were held with eligible couples.
- For each tribe, key informant interviews were conducted with:
  - Social activists
  - Herbal practitioners (specialists)
  - Modern doctors and health workers at Mission hospitals and government hospitals.

Print Date

October 2008

Report Findings and Recommendations

Situational analysis

- Tribal populations have led impoverished lives, and the state is ranked at the bottom of most development rankings.
- Less than 10% of villages have electricity, and they lack roads and institutions in health, education, and services for women and children.
- Healthcare problems stem from illiteracy, poor infrastructure, poor sanitation, and some customs and traditions unique to tribes.
- Programs by the GOI to improve welfare among tribal populations have not impacted health service utilization, however, there is a willingness among stakeholders to engage traditional and government systems if opportunities are made available.

Accessibility of health services

- Most modern health services are provided by local RMPs.
- ANMs are less available in remote areas.
- AWWs are present but do not deliver healthcare services.
- Traditional doctors (vaid rajs) and untrained birth attendants (dais) are accessible, however, not integrated with the government healthcare system.

Recommendations for Tribal Populations

- There is an immediate need to ensure availability and accessibility of services to tribal and rural populations, and institute tribal-friendly health services in remote areas.
- There is a large unmet need for FP, and opportunity to promote tubectomy and IUDs.
- There is also a need to reconsider the Primitive Tribal Groups (PTGs) policy that bans the promotion of FP among endangered tribes.
- ICDS must be universalized and quality output should be monitored in child healthcare facilities. ICDS data must be disaggregated to understand and inform policy and action.
- Empower local populations to plan for and monitor health at the hamlet level through Village Health Committees and Sahiyas.
- Ensure functional health and nutrition facilities in every village:
  - Anganwadi center in each village
  - Adequate and efficient health sub-centers
  - CHCs and PHCs for tribal areas in all scheduled districts.
- Ensure healthcare facilities are tribal-friendly with workers from tribal villages fluent in local dialects.
- Encourage local tribes to manage public relations.
- Institutionalize traditional healing practices through universities and research institutes, promote vaid raj in each village, and document and provide platforms for sharing and dialogue

Capacity Building

Intra-Communication Workshop for the Jharkhand Health Society (JHS)

The MOHFW, Government of India has initiated a move for intra-communication amongst the stakeholders of the public health delivery system. This initiative under the NRHM aims at optimizing organizational synergies through intra-communication. IFPS-II is engaged in working with the Government of Jharkhand to improve the capabilities and deliveries of the public health system in the state through communication. As part of this effort, IFPS-II has undertaken a pilot initiative to deliver and evaluate the effectiveness of intra-communication capacity building activities.

Strategic Approach and Objectives

Through a participatory process, build capacity for intra-communication between Jharkhand health program managers and workers to build skills in employing basic concepts of communication, and add value to the process of developing district IEC plans.

Audience

ANMs and doctors

Duration

December 2007 – March 2008

Interventions and Activities

Workshops were held in two districts, Deoghar and Lohardaga. Workshop sessions employed interactive and participatory approaches such as question-and-answer sessions, anecdotes, games, team exercises, and practice sessions. Topics covered included:

- Elements of communication processes
- Basics of effective communication
- Identification of communication tools (IPC, mid-media, mass media)
- Development of simple reporting and monitoring formats
- Development of templates for community wall newspapers

Results

- Thirty-two ANMs and 16 doctors participated and gained skills in effective IPC, report writing, use of IPC tools such as flipcharts and posters, and designing and developing wall newspapers and newsletters.
- ANMs expressed a willingness to write event reports following visits with clients, and to use IPC tools taught through the workshop to improve their communication skills.
- A core team of ANMs and doctors in each district was equipped and motivated to lead the intra-communication initiative in their communities following the pilot.

IPC Capacity Building of Sahiyas

Effective IPC between healthcare providers and clients is one of the most important elements for improving client satisfaction, prevention, treatment adherence, and health outcomes. Effective IPC also benefits the health system by making it more efficient and cost-effective. Thus, clients, providers, administrators and policymakers all have a stake in improved provider-client interactions. The Government of Jharkhand recognized the need for more effective IPC among Sahiyas.

Strategic Approach and Objectives

Through a ToT and subsequent cascade training model, build capacity for IPC and counseling skills among Sahiyas and ANMs.

Audience

Sahiyas and ANMs from Bokaro and Gumla districts

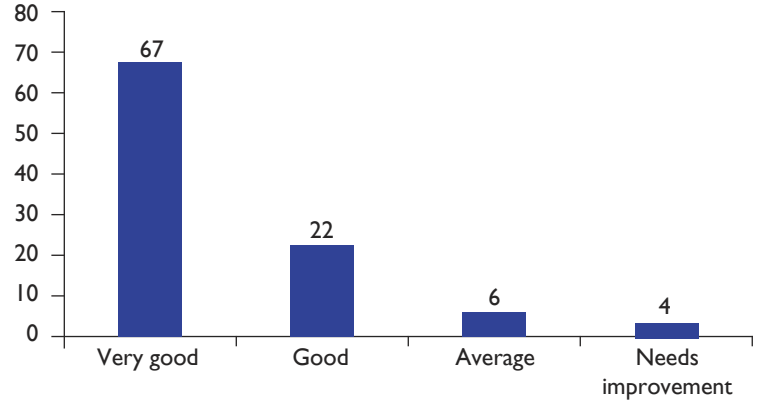
Interventions and Activities

- A model ToT plan on IPC focusing on client provider interaction was developed.

G Greet client (establish rapport)
A Ask client (gather information)
T Tell (provide information)
H Help client with problem-solving and decision-making
E Explain to the client key information for the decision
R Return/Refer/Reality check

- Training material prototypes, curricula, and job aids were developed, pre-tested, and finalized.
- A ToT Toolkit was developed with materials for master trainers and Sahiyas.
- A follow-up and supervision plan was developed.

IPC Training Feedback by Master Trainer: Average rating of participants



Toolkit Materials for Sahiyas

Sahiya Box
An easy-to-carry box with contraceptive samples and takeaways for use as a facilitation and demonstration tool.

Reference Book
A book for Sahiyas on FP with case studies from the field. This booklet fits into the toolkit.

Takeaways
40 takeaways for men and 40 takeaways for women that Sahiyas leave behind after counseling, with information about contraceptive choices for men and women separately.

Toolkit Materials for Master Trainers

Facilitator's Guide
It includes detailed training curriculum and agenda to train and supervise Sahiyas in IPC.

Instructional Video on Counseling Steps for FP
It includes case studies that can be analyzed to understand steps of counseling and skills of a good counselor.

Sahiya Materials
All the materials that the Sahiyas have in their toolkit

- ToT training sessions were delivered.
  - Three-day trainings trained master trainers on the GATHER approach, strengthening their training skills.
  - Mock training sessions with feedback from facilitators were held with master trainers.
- An assessment of the training was conducted.

Duration
August 2009

Results
- Through pre-testing, 10 master trainers and 20 Sahiyas identified changes for the development of the final training module and materials.
- 122 master trainers were trained over five sessions.
- 67% of participants rated the training as very good.
  - Most liked sessions were role plays of counseling situations (78% of participants), mock training sessions (67%), and steps of counseling (56%).

Demand Generation for Family Planning Services

IPC and BCC Campaign, and Material Development for Sambhav Voucher Scheme

Many FP and RCH services are not available or are inaccessible to vulnerable populations through the public healthcare system, and often, poor families are forced to seek services from a costly and unregulated private sector causing severe economic distress. This is a barrier to accessing services for the most vulnerable populations. The rate of healthcare service seeking through private health providers in Jharkhand, as in all of India, is high with over two-thirds of the population seeking private services (Reference: National Sample Survey Organisation. Consumer expenditure, employment: unemployment, morbidity, health care and condition of the aged. NSS 60th round (January 2004-June 2004). New Delhi: Ministry of Statistics and Programme Implementation, Government of India; 2006 Mar). The voucher scheme allows the government to reduce the financial burden of the poor when they access services in the private sector by linking vulnerable groups to critical FP and RH services free of cost at accredited private health centers. The voucher scheme provides low income families with a set of coupons, given by ASHAs or Sahiyas, to obtain free FP and RCH services from designated providers. The government reimburses private healthcare providers for services performed under the scheme on a previously agreed fee schedule, and monitors services to ensure high quality.

Effective IPC between healthcare providers and clients further impacts healthcare seeking and service utilization, and is recognized as one of the most important elements for improving client satisfaction, adherence and health outcomes. Effective IPC also benefits the healthcare system as a whole by making it more efficient and cost-effective. Thus, clients, providers, administrators and policymakers all have a stake in improved client-provider interactions. Effective IPC

was therefore, determined to be of critical importance in improving service utilization through the private sector.

There was a need to increase awareness, access to, and use of FP and RCH voucher services through private providers through demand generation BCC and more effective client-provider IPC.

Strategic Approach and Objectives

Develop and deliver demand generation activities for below poverty line (BPL) populations to increase healthcare seeking and service utilization through private healthcare providers using the voucher scheme.

- Generate demand among BPL families for the use of the FP voucher scheme through private healthcare facilities by increasing knowledge and awareness, and increase use of services for:
  - No-scalpel vasectomy (NSV)
  - Female sterilization
  - IUD
  - Injectables
  - Condoms
  - OCPs
  - Standard Days Method.
- Improve effectiveness of IPC and build counseling skills of Sahiyas, ANMs and AWWs.

Audience

- Couples with one or more children
- Couples who have reached their desired family size and wish to have no more children
- Mothers-in-law and other key decision-makers within the household
- Service providers in the public and private sector.

Duration

2008 – 2010

Interventions and Activities

- Completion of a communication needs assessment to analyze:
  - Access to information on FP (methods, importance, use, benefits and barriers)

- Knowledge about availability of FP services
- Preferred source of services and products, and reasons for preferences
- Motivating factors and barriers to FP service access and adoption
- Identifying myths and misconceptions related to FP methods
- Preferred and available channels of communication.

- Testing of existing voucher scheme, demand generation materials from Uttarakhand (can be seen in the Uttarakhand section) including flipbooks, leaflets, and posters to determine if materials were relevant or adaptable to Jharkhand based on:
  - Comprehension and appeal of messages, flow of content, and visuals
  - Retention of visuals and messages
  - Cultural relevance of visuals and messages
  - Appropriateness of type of materials: visibility, ease of handling, portability, and ease of material dissemination and storing.
- Capacity building training on IPC for Sahiyas, ANMs and AWWs with semi-annual meetings for problem solving, and sharing best practices and lessons learned.
- Develop a Voucher Management Agency (VMA) to manage the scheme with responsibilities of:
  - Identifying intended beneficiaries
  - Training healthcare staff at accredited private hospitals on quality standards
  - Establishing a financial disbursement system for advancing funds and reimbursing private hospitals for voucher services
  - Managing project management information systems (MIS), conducting periodic quality audits, and seeking beneficiary feedback
  - Disbursing and managing incentives given to Sahiyas, and the reimbursement of transportation costs to beneficiaries.

Lessons Learned and Promising Approaches

Lessons were learned through the development of the Jharkhand BCC strategy, and findings from the evaluation of healthcare seeking practices of special populations indigenous to Jharkhand, as well as from the formative assessment of voucher scheme materials.

- A collaborative, inclusive, and participatory approach is critical to the adoption of programs and services for specific populations where social and cultural factors heavily influence behavior at all levels.
- Individual campaigns or isolated approaches are less effective than activities stemming from a broad, evidence-based, data-informed strategy.
- BCC programs that integrate health topics, BCC messages, and complimentary delivery approaches – such as state level mass media promoting services through Sahiyas, and a community level folk performance demonstrating Sahiyas' skills – can effectively reinforce messages to intended audiences.
    - This was demonstrated through the state strategies developed and implemented in both Jharkhand and UP.

What Works

- Collaborative, coordinated approaches to BCC strategy development.
- Inclusion of special or at-risk populations in BCC development.
- Consideration of unique cultural and social factors in barriers and behavior change interventions for healthcare service usage.
  - Tribal populations may have needs and opportunities not previously explored.
  - Demand generation for healthcare services in tribal communities relies upon well-informed solutions.
- Empowerment of frontline healthcare providers is key to effective BCC.
  - Well-trained and well-equipped frontline workers in the private and public sector can increase demand for FP healthcare products and services.

BCC activities implemented in Jharkhand highlight the unique needs and opportunities for health behavior change. Through strategy development, intervention delivery, and evaluation, several promising approaches for effective BCC were demonstrated in Jharkhand.

- Strategic BCC planning that follows proven models of health communication and includes a situation analysis, communication objectives, priority areas for focus, and training and capacity building of key healthcare providers in facilities and communities; and consideration and strengthening of operational capacities can be a very effective approach for comprehensive and coordinated BCC.
- BCC development through a collaborative, integrated, and coordinated process including multiple levels of stakeholders in the public and private sector, and representatives from special populations can successfully empower communities and healthcare providers to develop and deliver the most culturally and socially relevant programs.
  - Audience segmentation, and tailored intervention delivery mechanisms to segmented audiences, are necessary to reach communities that are diverse and may pose additional challenges, such as tribal populations in Jharkhand.
- Capacity building of ANMs and Sahiyas as the only health service providers accessible to some tribal communities, and training and inclusion of traditional healers in service delivery plans, effectively demonstrated this approach.
- Empowerment of frontline healthcare providers such as private doctors, Sahiyas, ANMs and master trainers through capacity building, and the provision of culturally appropriate tools can effectively increase knowledge, generate community demand, and improve healthcare service utilization.

SECTION IV

Behavior Change Communication

Uttarakhand

SECTION IV

Behavior Change Communication

Uttarakhand

Mass Media

Jug Jug Jiyo (Blessed be Thee) Institutional Delivery Campaign

Populations in Uttarakhand prefer home deliveries based on formative research conducted in 2006. Rates of women delivering in an institution and delivering with a trained health professional are lower in Uttarakhand than in India overall.

NFHS-3 (2005-06)	Uttarakhand	All India
Birth delivered in a health facility	32.6%	38.7%
Births delivered by a trained health professional	38.5%	46.6%

In mid hill and upper hill regions, accessibility to service delivery points and faith in TBAs (*dais*) are key determinants for home delivery preference over institutional delivery. In the lower plains, low cost of delivery at home, coupled with a home-focused environment and faith in *dais* are key factors for preferring home delivery to institutional delivery. The general practice is that institutional deliveries are only chosen in case of emergencies or when a *dai* refers the family to a hospital or health center due to birth complications.

Strategic Approach and Objectives

Through mass media, promote the benefits of institutional births, focusing on increasing delivery in the private sector through:

- Increased awareness and utilization of the JSY (safe motherhood scheme) which provides incentives for institutional delivery
- Increased knowledge of birth danger signs and complications
- Increased knowledge of birth preparedness and birth planning
- Increased awareness of and confidence in ASHAs in delivering BCC for FP and RCH services.

Develop BCC materials that utilize appropriate language, and cultural and social representations.

TV Airings

Doordarshan	12 times daily
TV-100	4 times daily
Sahara Samay	4 times daily
ETV Uttarakhand	4 times daily

Audience

Primary

Couples of reproductive age and newly married couples

Secondary

- Mothers-in-law or elder women, and women heads of households
- Healthcare providers, specifically ASHAs, ANMs, and hospital staff

Duration

Aired in September 2007, and repeated between January-March 2009

Interventions and Activities

- Identify a campaign promise and benefit: *"Enroll yourself today in the JSY program and ensure a safe, secure and affordable[3] environment for delivery of your baby".*
- Develop samples of creative ideas for printed materials including brochures, calendars, posters, stickers, and "Q" cards illustrating the JSY program and how to access the program and its benefits.
- Develop IPC materials for community healthcare workers.
- Develop folk media scripts and mass media TV or radio spots.
  - A media plan was developed to ensure high reach and frequency for key audiences.
- Provide the spots to the Uttarakhand Health Society for airing on TV and radio, and printed materials for distribution.

Results

The materials and media plan were provided to the Uttarakhand Health Society. TV spots were aired 24 times daily on national and regional channels during the promotion period.

Rates of childhood immunization for any illness in Uttarakhand are generally better than rates for all of India. However, there are almost twice as many children in Uttarakhand receiving no vaccination compared with India overall. The higher rates of full and disease-specific vaccinations for Uttarakhand children highlight the importance of initiating the immunization cycle, increasing the potential for disease-specific and full vaccinations, and healthier children across the state.

[3] Affordable: The JSY program is meant for BPL families, but the program does not exclude non-BPL families in delivering a baby at public health facilities.

Childhood Immunization Campaign

NFHS-3 (2005-06)	Uttarakhand	All India
BCG vaccine for TB	83.5%	78.1%
Polio 0 (at birth)	51.8%	48.4%
Measles	71.6%	58.8%
Full vaccination	60.0%	43.5%
No vaccination	9.1%	5.1%

Strategic Approach and Objectives

Develop a communication strategy that focused on reducing high vaccination dropout rates, and achieving 100% routine immunization in Uttarakhand by:

- Promoting "full immunization" for children before their first birthday
- Encouraging every parent to finish a series of vaccine visits at health centers or a place where immunization services are provided before the first birthday of the child
- Improving image of the health workers who administer vaccines among parents and communities.

Audience

Primary

Caregivers (fathers and mothers) of children under 12 months, 18-30 years, living in rural and urban areas who have not fully immunized their children

Secondary

Elders in the family, and village influencers including religious leaders, ANMs, ASHAs, and AWWs

Duration

Aired in September 2007, and repeated between January-March 2009

Interventions and Activities

- Identify a campaign promise and benefit: *"If you have fully immunized children, you will join the family of proud and responsible parents whose children are protected against six killer diseases".*

- Develop samples of creative ideas for printed materials including brochures, calendars, posters, stickers, and "Q" cards to increase access to the program and its benefits.
- Develop IPC materials for community and facility healthcare workers.
- Develop plans for outreach activities to increase attendance at public health facilities on immunization days.
- Develop folk media scripts and mass media TV or radio spots.
- A media plan was developed to ensure high reach and frequency for key audiences.
- Provide the spots to the Uttarakhand Health Society for airing on TV and radio, and printed materials for distribution.

Results

The materials and media plan were given to the Uttarakhand Health Society. TV spots were aired 24 times daily nationally and regionally during the promotion period.

Capacity Building

Training and Tools for the ASHA-Plus Scheme

The NRHM aims to employ one ASHA for every 1,000 people, however, given Uttarakhand's hilly terrain, houses are distant and sparsely situated, and health services are difficult to access. Because of these unique challenges, under the ASHA-Plus program in the state, each ASHA serves 500 people. Additionally, in Uttarakhand, there is very low media access, and a highly trained and well-equipped ASHA may be the only skilled healthcare provider available to many households. It is critical that ASHAs in these regions receive enhanced training on FP and RCH products and services, and be well-equipped with tools for effective IPC, health needs assessments, and referrals to hospitals or clinics. To deliver services through ASHAs with enhanced training and tools, the Government of India called for the scale up of the ASHA-Plus Scheme in Uttarakhand.

Strategic Approach and Objectives

- Build increased capacity among ASHAs, the primary and at times only trained healthcare provider accessible by communities, and equip ASHAs with tools to improve health of women and children by promoting:
  - Improved healthcare seeking behaviors among pregnant women
  - Institutional delivery through the JSY
  - Improved home-based newborn care
  - Routine immunization for children.
- Build increased capacity among ASHAs to deliver effective BCC through IPC on hygiene, sanitation and nutrition.
- Build increased capacity among ASHAs to effectively facilitate group meetings on priority health issues, and develop effective linkages with health program managers and PRIs.
- Revitalize the Village Health and Sanitation Committee (VHSC) with support of ASHAs, supervisors, ANMs and AWWs.

Audience
ASHAs in Uttarakhand

Duration
Pilot phase: 2007 – 2009

Scale Up
Began in 2009

Interventions and Activities
Given the limited access to healthcare resources in Uttarakhand, and the greater need for services by ASHAs, the ASHA-Plus scheme provides the flexibility, enhanced training, and job aids needed to support an enhanced level of health services. Unlike the ASHA, the ASHA-Plus worker uses simplified and more illustrative training materials and job aids such as flipcharts on FP and RH choices to help perform their work, and is supported by a robust MIS that streamlines the workflow.

The ASHA-Plus program was piloted in two blocks of Uttarkashi (Bhatwari and Purola), Chamoli (Karnaprayag and Joshimath), and Pithoragarh (Munsyari and Munakot) districts. One of the major components of this program was in-depth training of the ASHA-Plus workers on IPC, health interventions and community mobilization.

- A baseline survey was conducted in the six pilot blocks and three non-ASHA-Plus blocks to generate estimates of healthcare knowledge, awareness, and access, and identify gaps for training.
- Based on these findings, an ASHA-Plus training model and curriculum was developed.
  - The trainings followed a participatory approach with interactive discussions, group activities and group work, demonstrations and role plays, and audio-visual presentations.
  - Implementing communication activities, and developing communication materials were part of the training to encourage ASHAs to be self-reliant.
  - The training materials and curriculum leveraged existing health training materials and curricula from the Government of India. Content included training the ASHA in the life cycle approach and life skills education to identify needs of families and provide prioritized, need-based, client-centered services.
- A cascade training model was developed where master trainers, supported by representatives from the state and district health departments, and NGOs were trained by an independent agency, who then trained select ASHAs as master trainers in intervention blocks.

Results
Through the pilot program, 571 ASHAs were trained. The Uttarakhand Health and Family Welfare Society recognized the higher quality of healthcare provided by ASHA-Plus workers and began replicating the model across all 13 districts.

- A robust MIS was developed that included establishing a Technical Advisory Group to review program implementation.
  - ASHAs were provided registers for recording activities.
  - Monthly reporting formats, and Supervisor and Block

Coordinator monitoring formats were developed.

- Household survey formats were developed, and surveys conducted by ASHAs in their areas.
- Software was developed for MIS; social mapping and ELCO mapping was done by ASHAs for their coverage area.

- On an ongoing basis, the ASHA recruitment process, training process, and operating systems are documented to enhance the program.

Analysis of quarterly performance reports continually finds improvements in healthcare knowledge, awareness, access, and outcomes of the ASHA-Plus delivery process. MIS data show a steep increase in indicators related to early registration of pregnancies, institutional deliveries, immunization and other community issues like water, hygiene and sanitation.

Community Mobilization and Demand Generation

Mobile Health Vans

To increase access to health services in Uttarakhand, mobile vans were deployed providing diagnostics, health consultations, and FP products and services to communities with limited access to healthcare facilities. Through village-trained and led community mobilization, usage of services from mobile health vans improved during the pilot program launched in the Ram Nagar block of Nainital district. Based on this improvement, the Uttarakhand Health Society desired to scale up the mobile health van program. A communication strategy was needed to scale up the program and service usage.

Strategic Approach and Objectives

- Through a communication needs assessment, develop a communication strategy that focuses on benefits of the mobile van program to:
  - Increase awareness of health services available through the mobile van program, including information on schedules, costs, registration and medicines.
  - Increase utilization of mobile van services by focusing on the benefits of the program.
- Create a brand for the mobile van program that positions the van's health services as efficient, economical, and of high quality.
- Strengthen capacity of service providers and improve client-provider interactions.
- Strengthen skills of service providers in IPC, community mobilization and advocacy.

Audience

Primary

Married couples, adolescents

Other

Family elders and community opinion leaders, and ASHAs

Duration
Pilot phase
2007 – 2009

Scale Up
2010

Interventions and Activities
Commission a communication needs assessment to identify communication needs, and most effective channels to increase mobile van brand recognition, and message recall and comprehension. Based on the communication needs assessment, develop a branding and communication strategy and materials to promote the program and increase service uptake.

- Advocacy and awareness communication materials developed:
  - Posters, wall writings and paintings
  - Mobile SMS alerts, loudspeaker messages, and one-page van handouts
  - Community groups, street plays and puppet shows
  - Counseling takeaways and portable counseling materials.
- Branding
  - Brand name and logo
  - Van paintings
  - Merchandising.
- Capacity strengthening materials for van staff and ASHAs
  - Orientation programs
  - Training programs and refreshers.

FP/RCH services accessed
December 2007 – April 2008

Service	Clients
ANC	1,454
OCP cycles	1,908
IUCD	237
Condoms (10-pack)	5,406
Sanitary napkins	1,473
Total RCH Clients	5,566 (36% of total turnout)

Results
The mobile van initiative was fully functional from December 2007 until April 2008, during which 273 camps were held; 15,558 clients attended and received services in the camps, of which 67.4% were women, and 34.5% were from BPL families.

Linkages with stationary public health facilities and regular follow-up visits have maintained the credibility of services provided. In addition to medical services, the van staff has trained village health volunteers in mobilizing members of the community to seek RCH services, and to provide BCC.

The Uttarakhand Health Society replicated this model to scale it up to 13 districts across the state.

Family Planning Voucher Scheme

In Uttarakhand, existing health services are underutilized, and facilities are understaffed and under-equipped; accessibility to healthcare products and services is a major challenge. This environment, compounded by a geographically challenging landscape, presents problems to improving health in the region. A voucher system was developed and funded by the Government of India and donor agencies to reach vulnerable populations with subsidized, cost-effective health interventions.

The voucher scheme links vulnerable groups to critical FP and RH services by providing quality products and services to BPL families free of cost at public health facilities and accredited private health centers. ASHAs provide vouchers for services including sterilization for men and women, OCPs, condoms, IUCDs, institutional delivery, ANC, PNC, and newborn care. Families then take vouchers to health centers for services delivered at no cost.

By involving both public and private healthcare providers in the implementation of the voucher system, the Government of India is encouraging competition, while maximizing healthcare quality and access to recipients.

The voucher system aims to:

- Enhance RCH services and coverage among BPL populations.
- Provide access to quality healthcare services for mothers and children of BPL families.
- Establish a system for accrediting healthcare facilities, and ensuring quality of care.
- Provide a choice of service providers to members of the community.
- Expand services across additional health areas, and in geography.

The voucher system in Uttarakhand was originally piloted in Imlikheda and Bahadrabad blocks of Haridwar district where rates of institutional birth deliveries and childhood immunization are some of the lowest in the state. Less than one-third of women deliver babies in a health facility, less than 10% of women receive full ANC, and less than one-quarter of children are fully vaccinated so it was important to expand access to healthcare to communities in Haridwar (Reference: DLHS-3, 2007-08).

Following an approach similar to the development of the communication strategy for the mobile health van program, a communication strategy was developed for scaling up the voucher system in Uttarakhand.

Strategic Approach and Objectives

Through IEC/BCC media campaigns, capacity building, and advocacy:

- Generate demand for the voucher scheme by focusing on its benefits and quality of services.
- Inform beneficiaries about available services, eligibility criteria, and clinic locations and schedules.
- Increase awareness among eligible couples about FP products and services available through the voucher scheme.
- Increase self-efficacy of couples in making informed FP choices through improved IPC.
- Increase knowledge and awareness among families in ANC, PNC and neonatal care.
- Change attitudes of family elders and other influential leaders regarding spacing and limiting childbirth.
- Strengthen the capacity of service providers in client-provider interaction.

Audience

- Couples with one or more children
- Couples wishing to have no more children
- Mothers-in-law and other influencing family and community members
- Service providers in the public and the private sector
- Panchayati and other village leaders
- Media

Duration

2009 – 2010

Interventions and Activities

In December 2009, a needs assessment was conducted to assess communication needs and channels, and key barriers to accessing voucher scheme services. Based on the needs assessment, a BCC strategy and a set of materials were developed for use in scaling up the program.

- The strategy provides a log frame to achieve each program objective through a range of activities in households, communities, and

facilities, as well as mass media.

- Communication materials including flipbooks, leaflets, posters, and signboards for brand building were developed and distributed to ASHAs who were trained to use them for IPC and community mobilization.

The Uttarakhand Health Society screened a film with testimonials from voucher scheme beneficiaries through video vans. Each screening was followed by discussion and question-and-answer sessions, and health products were given away. Community leaders, including ASHAs, encouraged audiences to take advantage of services offered through the scheme, and vouchers were provided. The impact of this is yet to be assessed.

Understanding and Delivering to Address Adolescent Needs (UDAAN)

The Government of Uttarakhand, through the Himalayan Institute of Health Training (HIHT), developed and delivered a life skills education program for youth. This presented IFPS-II with a unique opportunity to enhance the existing HIHT youth program by adding messages addressing health, hygiene, choices about marriage and childbirth, and education. Utilizing HIHT's training module format, youth could be reached with BCC messages on these important topics. To accomplish this, the Understanding and Delivering to Address Adolescent Needs (UDAAN) program was developed.

Strategic Approach and Objectives

- Make healthcare services more accessible and acceptable to youth by building skills and capacity, and empowering youth to:
  - Increase utilization of services in adolescent-friendly clinics and counseling centers.
  - Improve health by positively impacting behaviors such as consumption of weekly iron folate supplements, and improved menstrual hygiene for girls.
  - Reduce unhealthy high risk behaviors through empowerment for abstinence from smoking, drinking, and sexual activity.
  - Delay age at marriage for boys and girls.
  - Reduce school dropout rates.
- Build skills and capacity, and empower parents to tackle barriers that make it difficult for youth to access services.
- Increase service usage at adolescent-friendly clinics by setting standards and expectations for quality.
- Build capacity of healthcare providers to improve service delivery in adolescent-friendly clinics.

- Establish a convergence of stakeholders in providing a comprehensive package of services for adolescents based on their needs.

Audience

- Youth 14 – 19 years
- Rural school going and out-of-school adolescent boys and girls
- Married adolescents

Duration

August 2009 – May 2010

Interventions and Activities

- Conduct a formative evaluation to understand the communication needs, aspirations and role models of the adolescents.
- Develop a BCC strategy for the UDAAN program, and an integrated campaign and related materials to advocate for adolescent needs and rights, inform adolescents about healthcare, inform caregivers about their role, increase demand for adolescent services, and change attitudes of adolescents, caregivers, and service providers towards adolescent health.
- Develop training modules following the structure of HIHT's existing modules for youth in key areas:
  - Marriage and FP
  - Awareness of disease and vaccination
  - Hygiene practices
  - Utilization of health services
  - School going habits
  - Personality issues.
- Twenty-five different types of materials were developed including interactive board games, storybooks, healthy lifestyle booklets, leaflets, dispensers for socially marketed products, posters, banners, letter boxes, referral cards, and birth preparedness kits.

The UDAAN Campaign

'Taiyaar Ho' (Get Ready)

This inspirational campaign motivates adults to help adolescents get ready for a healthy, successful and bright future. Materials display youthful animation, and use bright colors depicting energy and vigor.

Results

The module and materials were completed and given to the Uttarakhand Health Society in May 2010, which will distribute, and train facilitators on integrating UDAAN into the existing youth program.

Lessons Learned and Promising Approaches

Social customs adhered to by families and community gatekeepers present unique barriers to programs that seek to increase uptake of services. Barriers must be understood through formative assessment, and can be addressed with participatory and collaborative approaches.

- Challenges remain in increasing access to healthcare products and services in key populations.
  - Services are inadequate to address the perceptions, barriers and needs of youth.
  - Providers are ill-equipped to address the needs of youth.

Before scaling up programs, pilot programs can provide useful data that saves unnecessary time and costs. This was demonstrated in the successful scale up of the mobile van program, and re-design of voucher scheme communication materials that was needed as a result of implementation before the pilot assessment was completed.

- The rapid assessment of the voucher scheme demonstrated the need to reduce text, increase visuals, and portray local representations of people in communication materials.

Through the development of strategic BCC campaigns for key health issues in this unique region of India, new insights were gained in addressing communication needs

What Works

- Communication 'needs assessments' for unique audiences and populations.
- Fixed dates and service delivery points establish credibility of services, and can be effective BCC.
- Community mobilization and outreach through mobile clinic providers increases access to FP and RH products and services.
- Scaling up pilot programs is most effective if assessment, monitoring and evaluation are components throughout the design, development, training and implementation process.

where traditional channels may not exist.

- Communication needs assessments are critical to the development of communication strategies for specific audiences that may be difficult to reach, such as healthcare providers in remote areas, or adolescents.

Through capacity building, providers of healthcare services themselves can be very effective media channels for communicating programs and services where other communication channels are poor or non-existent.

- IPC
- Positive client-provider interactions
- Mass and mid-media, such as loudspeaker announcements and van paintings.

Existing and accepted structures can be utilized to expand or enhance healthcare capacity building among critical participants or audiences, effectively leverage resources, and increase stakeholder participation.

- Developing training modules for youth that expand on youth modules delivered by HIHT.
- Enhancing skills of ASHAs through the expansion of the ASHA-Plus scheme.

List of Resources

The list of resources provided below was used in developing this report.

Section 1: National Level

Proposed BCC Plan of Action for FP for the NRHM for July 2009-March 2010
BCC Plan of Action for FP for the NRHM for July 2009-March 2010: Phase Matrix
National IEC Workshop Report
NRHM Advocacy Film Proposal by Relative Media
MCH-STAR Evaluation Top Line Findings Presentation
MCH-STAR Evaluation
Atmajaa Proposal
Study on Assessing the Visibility, Comprehension and Recall of TV campaigns aired under the NRHM

Section 2: Uttar Pradesh (many of these resources can be found at: www.sifpsa.org)

BCC Strategy for the NRHM in Uttar Pradesh
Interview with Rita Banerjee
Interview with Geetali Trivedi
Background document on the ASHA Newsletter
ASHA Newsletter Presentation
Rapid Qualitative Assessment Key Findings
Mid-Term Evaluation Report: Radio Drama Series
Project Management Unit Guidelines for Sterilization
Interviews with SIFPSA staff
PAC Presentation (PowerPoint)
Kumbh Mela PAC Project Summary Report
SIFPSA information sheet

Section 3: Jharkhand

Objectives of the Jharkhand BCC Strategy Development Workshop Presentation
Health Communication Strategy Jharkhand
Health Issues and Health Seeking Behavior of Tribal Populations
Intra-Communication Workshop Report and Summary
Proposal for BCC Vouchers, District Dhanbad; September 1, 2009
Proposal for BCC Vouchers, District Gumla-GN; August 6, 2009
Proposal for Jharkhand Needs Assessment

Section 4: Uttarakhand

Proposal for BCC-Institutional Deliveries, Uttarakhand
ASHA Training Program Implementation Framework Presentation
ASHA-Plus Project: IFPS-II Technical Assistance Project Presentation November 26, 2007
Mobile Van BCC Plan-Uttarakhand ITAP Report September 3, 2009
Motivating Rural Communities Presentation by the Technical Advisory Group
Vikalp Formative Research Pilot Report
Communication Plan Mobile Van Formative Report
BCC strategy for Voucher Scheme in Uttarakhand
Haridwar Voucher Scheme Rapid Assessment
UDAAN BCC Plan September 9, 2009
BCC Plan – Adolescent Health Presentation August 8, 2009

Index of Select Topics

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